HEARING DATE AND TIME: September 27, 2012 at 10:00 a.m. (Eastern Time)
RESPONSE DEADLINE: September 14, 2012 at 4:00 p.m. (Eastern Time)

THE THREE HUNDRED FORTY-FIRST OMNIBUS OBJECTION TO CLAIMS SEEKS TO DISALLOW AND EXPUNGE CERTAIN FILED PROOFS OF CLAIM. PARTIES RECEIVING THIS NOTICE OF THE THREE HUNDRED FORTY-FIRST OMNIBUS OBJECTION TO CLAIMS SHOULD REVIEW THE OMNIBUS OBJECTION TO SEE IF THEIR NAME(S) AND/OR CLAIM(S) ARE LOCATED IN THE OMNIBUS OBJECTION AND/OR THE EXHIBITS ATTACHED THERETO TO DETERMINE WHETHER THE OBJECTION AFFECTS THEIR CLAIM(S).

IF YOU HAVE QUESTIONS, PLEASE CONTACT LEHMAN BROTHERS HOLDINGS INC.'S COUNSEL, ERIKA DEL NIDO, AT 212-310-8323.

WEIL, GOTSHAL & MANGES LLP
767 Fifth Avenue
New York, New York 10153
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Robert J. Lemons

Attorneys for Lehman Brothers Holdings Inc.
and Certain of Its Affiliates

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re	:	**Chapter 11 Case No.**
	:	
LEHMAN BROTHERS HOLDINGS INC., *et al.*,	:	**08-13555 (JMP)**
	:	
Debtors.	:	**(Jointly Administered)**

NOTICE OF HEARING ON THREE HUNDRED FORTY-FIRST OMNIBUS OBJECTION TO CLAIMS (NO LIABILITY CLAIMS)

PLEASE TAKE NOTICE that on August 14, 2012, Lehman Brothers Holdings Inc. ("LBHI" and the "Plan Administrator"), as Plan Administrator under the Modified Third Amended Joint Chapter 11 Plan of Lehman Brothers Holdings Inc. and Its Affiliated Debtors for certain entities in the above-referenced chapter 11 cases, filed its three hundred forty-first

omnibus objection to claims (the "Three Hundred Forty-First Omnibus Objection to Claims"), and that a hearing to consider the Three Hundred Forty-First Omnibus Objection to Claims will be held before the Honorable James M. Peck, United States Bankruptcy Judge, in Courtroom 601 of the United States Bankruptcy Court for the Southern District of New York, One Bowling Green, New York, New York 10004, on **September 27, 2012 at 10:00 a.m. (Prevailing Eastern Time)**, or as soon thereafter as counsel may be heard.

PLEASE TAKE FURTHER NOTICE that any responses to the Three Hundred Forty-First Omnibus Objection to Claims must be in writing, shall conform to the Federal Rules of Bankruptcy Procedure and the Local Rules of the Bankruptcy Court, and shall be filed with the Bankruptcy Court (a) electronically in accordance with General Order M-399 (which can be found at www.nysb.uscourts.gov) by registered users of the Bankruptcy Court's filing system, and (b) by all other parties in interest, on a 3.5 inch disk, preferably in Portable Document Format (PDF), WordPerfect, or any other Windows-based word processing format (with a hard copy delivered directly to Chambers), in accordance with General Order M-182 (which can be found at www.nysb.uscourts.gov), and served in accordance with General Order M-399, and on (i) the chambers of the Honorable James M. Peck, One Bowling Green, New York, New York 10004, Courtroom 601; (ii) attorneys for LBHI, Weil, Gotshal & Manges LLP, 767 Fifth Avenue, New York, New York 10153 (Attn: Robert J. Lemons, Esq. and Mark Bernstein, Esq.); and (iii) the Office of the United States Trustee for Region 2, 33 Whitehall Street, 21st Floor, New York, New York 10004 (Attn: Tracy Hope-Davis, Esq., Elisabetta Gasparini, Esq., and Andrea B. Schwartz, Esq.); so as to be so filed and received by no later than **September 14, 2012 at 4:00 p.m. (Prevailing Eastern Time)** (the "Response Deadline").

PLEASE TAKE FURTHER NOTICE that if no responses are timely filed and

served with respect to the Three Hundred Forty-First Omnibus Objection to Claims or any claim set forth thereon, the Plan Administrator may, on or after the Response Deadline, submit to the Bankruptcy Court an order substantially in the form of the proposed order annexed to the Three Hundred Forty-First Omnibus Objection to Claims, which order may be entered with no further notice or opportunity to be heard offered to any party.

Dated: August 14, 2012
New York, New York

/s/ Robert J. Lemons
Robert J. Lemons

WEIL, GOTSHAL & MANGES LLP
767 Fifth Avenue
New York, New York 10153
Telephone: (212) 310-8000
Facsimile: (212) 310-8007

Attorneys for Lehman Brothers Holdings Inc.
and Certain of Its Affiliates

HEARING DATE AND TIME: September 27, 2012 at 10:00 a.m. (Eastern Time)
RESPONSE DEADLINE: September 14, 2012 at 4:00 p.m. (Eastern Time)

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Robert J. Lemons

Attorneys for Lehman Brothers Holdings Inc.
and Certain of Its Affiliates

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re	**:**	**Chapter 11 Case No.**
LEHMAN BROTHERS HOLDINGS INC., *et al.*,	**:**	**08-13555 (JMP)**
Debtors.	**:**	**(Jointly Administered)**

THREE HUNDRED FORTY-FIRST OMNIBUS OBJECTION TO CLAIMS (NO LIABILITY CLAIMS)

THIS THREE HUNDRED FORTY-FIRST OMNIBUS OBJECTION TO CLAIMS SEEKS TO DISALLOW AND EXPUNGE CERTAIN FILED PROOFS OF CLAIM. PARTIES RECEIVING THIS THREE HUNDRED FORTY-FIRST OMNIBUS OBJECTION TO CLAIMS SHOULD REVIEW THE OMNIBUS OBJECTION TO SEE IF THEIR NAME(S) AND/OR CLAIM(S) ARE LOCATED IN THE OMNIBUS OBJECTION AND/OR THE EXHIBITS ATTACHED THERETO TO DETERMINE WHETHER THIS OBJECTION AFFECTS THEIR CLAIM(S).

IF YOU HAVE QUESTIONS, PLEASE CONTACT LEHMAN BROTHERS HOLDINGS INC.'S COUNSEL, ERIKA DEL NIDO, AT 212-310-8323.

TO THE HONORABLE JAMES M. PECK
UNITED STATES BANKRUPTCY JUDGE:

Lehman Brothers Holdings Inc. ("LBHI" and the "Plan Administrator"), as Plan Administrator under the Modified Third Amended Joint Chapter 11 Plan of Lehman Brothers Holdings Inc. and Its Affiliated Debtors (the "Plan") for the entities in the above-referenced chapter 11 cases (the "Chapter 11 Estates"), respectfully represents as follows:

Relief Requested

1. The Plan Administrator files this omnibus objection, pursuant to section 502(b) of title 11 of the United States Code (the "Bankruptcy Code"), Rule 3007(d) of the Federal Rules of Bankruptcy Procedure (the "Bankruptcy Rules"), and this Court's order approving procedures for the filing of omnibus objections to proofs of claim [ECF No. 6664] (the "Procedures Order"), seeking to disallow and expunge certain claims for which the Chapter 11 Estates have no liability.

2. The Plan Administrator seeks to disallow and expunge the applicable portions of each proof of claim listed on Exhibit A annexed hereto (collectively, the "No Liability Claims") filed against the Chapter 11 Estates because the No Liability Claims assert claims related to employee medical benefits, including claims for loss of coverage, claims associated with COBRA (defined below) coverage, and claims for reimbursement of medical expenses, for which the Chapter 11 Estates have no liability.[1]

Jurisdiction

3. This Court has jurisdiction to consider this matter pursuant to 28 U.S.C. §§ 157 and 1334. This is a core proceeding pursuant to 28 U.S.C. § 157(b).

[1] The Three Hundred Forty-First Omnibus Objection to Claims is only seeking to expunge the No Liability Claims. The Three Hundred Forty-First Omnibus Objection to Claims does not have any effect on portions of claims, if any, that are based on claims other than the No Liability Claims. The Chapter 11 Estates reserve all rights to object to or seek to reclassify such claims.

Background

4. Commencing on September 15, 2008, and periodically thereafter, LBHI and certain of its subsidiaries commenced with this Court voluntary cases under title 11 of the Bankruptcy Code. These chapter 11 cases have been consolidated for procedural purposes only and are being jointly administered pursuant to Bankruptcy Rule 1015(b).

5. On January 14, 2010, the Court entered the Procedures Order, which authorizes the filing of omnibus objections to no more than 500 claims at a time, on various grounds, including those set forth in Bankruptcy Rule 3007(d) and those additional grounds set forth in the Procedures Order, including that "the Claims seek recovery of amounts for which the Debtors are not liable." *See* Procedures Order at 2.

6. On December 6, 2011, the Court entered an order confirming the Plan. The Plan became effective on March 6, 2012 [ECF No. 23023]. Pursuant to the Plan, the Plan Administrator is authorized to interpose and prosecute objections to claims filed against the Chapter 11 Estates.

The No Liability Claims Should Be Disallowed and Expunged

7. Section 502(b)(1) of the Bankruptcy Code provides, in relevant part, that a claim shall not be allowed to the extent that "such claim is unenforceable against the debtor and property of the debtor, under any agreement or applicable law." 11 U.S.C. § 502(b)(1). If an objection refuting at least one of the claim's essential allegations is asserted, the claimant has the burden to demonstrate the validity of the claim. *See In re Oneida, Ltd.*, 400 B.R. 384, 389 (Bankr. S.D.N.Y. 2009); *In re Adelphia Commc'ns Corp.*, No. 02-41729 (REG), 2007 Bankr. LEXIS 660 at *15 (Bankr. S.D.N.Y. Feb. 20, 2007); *In re Rockefeller Ctr. Props.*, 272 B.R. 524, 539 (Bankr. S.D.N.Y. 2000).

8. The Chapter 11 Estates have no liability for the No Liability Claims for the reasons set forth below.

Benefits Plan Claims

9. Certain of the No Liability Claims assert that LBHI is liable for the loss of medical benefits coverage. The Chapter 11 Estates are not liable for claims for loss of coverage. The Summary Plan Description for the Lehman Brothers Holdings Inc. Group Benefits Plan (the "Benefits Plan"), attached hereto as Exhibit B, provides that the Benefits Plan can be changed or discontinued at any time without prior notice:

> ***Lehman Brothers reserves the right to change or discontinue any of these benefits and programs at any time without prior notice.*** This includes, but is not limited to, the level of benefits, eligibility for benefits, and cost to participants. *See* Benefits Plan at 3 (emphasis added).
>
> The self-funded benefits under the Plan (the Medical Plan, Dental Plan and the Flexible Spending Accounts) are funded by employee and Firm contributions. ***Benefits under these self-funded benefits are not guaranteed or insured.*** Firm contributions are made directly from general assets of the Firm. *See* Benefits Plan at 124 (emphasis added).
>
> As with the plans covering active employees, ***Lehman Brothers reserves the right to change or discontinue any of these benefits and programs at any time without prior notice.*** This includes, but is not limited to, the level of benefits, eligibility for benefits and any cost to participants. The fact of your retirement does not provide you with any vested right to any retiree coverages. *See* Benefits Plan at 56 (emphasis added).

The terms of the Benefits Plan clearly establish that the Chapter 11 Estates are not liable for the No Liability Claims based on loss of coverage.

COBRA Claims

10. Certain of the No Liability Claims assert that LBHI is liable for claims related to continuation medical coverage under the Consolidated Omnibus Budget Reconciliation

Act of 1986 ("COBRA"), including claims against LBHI for payment of COBRA premiums and damages in connection with the amount of COBRA premiums.

11. The Benefits Plan clearly provides that COBRA coverage is the responsibility of the beneficiary of the Benefits Plan:

> As part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and/or your eligible dependents who lose coverage under any of the Firm-sponsored health care plans (the Medical, Dental or Vision Care Plans and the Health Care Spending Account) as a result of the circumstances described in the chart below (called qualifying events) can continue coverage through the Firm ***at your (or your dependents') own expense***. *See* Benefits Plan at 89 (emphasis added).

The terms of the Benefits Plan establish that the Chapter 11 Estates are not liable for the payment of COBRA coverage and are not liable for the No Liability Claims that assert a claim related to COBRA coverage.

12. Certain of the No Liability Claims assert a claim for payment of COBRA benefits based upon severance agreements. Such severance letters provide:

> In addition, Lehman will pay for the cost of your COBRA coverage through no later than March 10, 2009 if you are not otherwise eligible to be covered by any other group health insurance plan. If you become eligible to participate in another group health insurance plan during your period of COBRA coverage and prior to March 10, 2009 you must notify the Human Resources Service Center (212-526-2363) at which time Lehman will discontinue this coverage.

The severance letters further provide that continued COBRA coverage will be at the employees' own expense and shall be provided in accordance with the terms of the Benefits Plan:

> You and your covered dependents, pursuant to the COBRA Law, may be eligible to continue health insurance coverage for up to 18 months from your separation date, at your own expense. Your right to continue or convert coverage (including COBRA coverage) after your separation date will be governed by the terms of our plans.

> Your rights to benefits under any employee benefits plans will be determined in accordance with the terms of such plans. Our employee benefits plans may be modified or terminated at any time.

13. The Chapter 11 Estates reviewed their records and determined that each claimant that asserted a claim for COBRA coverage based upon severance letters was not an employee of any of the Chapter 11 Estates, but was an employee of another Lehman entity, such as Lehman Brothers Inc. A claim against an entity other than the Chapter 11 Estates does not result in a claim against, or a right to payment from, any of the Chapter 11 Estates. As a result, the employers of the claimants may be liable for such compensation claims, but neither the records of the Chapter 11 Estates nor the No Liability Claims themselves provide any ground for liability by any of the Chapter 11 Estates for the No Liability Claims that assert a claim that LBHI is liable for COBRA payments based upon severance letters.

Reimbursement Claims

14. Certain of the No Liability Claims assert claims against LBHI for reimbursement checks issued by third parties to the claimant that the claimant failed to deposit. The Chapter 11 Estates are not liable for reimbursement of medical expenses. Under the terms of the Benefits Plan, the Employee Benefit Plans Committee of Lehman Brothers Holdings Inc. (the "Committee") appointed a "Claims Administrator," Aetna Life Insurance Company, to administer and process claims submitted under the Benefits Plan. *See* Benefits Plan at page 125. Furthermore, a claimant's failure to deposit a check issued by a third party does not result in a liability against any of the Chapter 11 Estates.

15. Unless the No Liability Claims are disallowed and expunged, parties who do not hold valid claims against the Chapter 11 Estates may nonetheless recover from the

Chapter 11 Estates. LBHI respectfully requests that the Court enter an order disallowing and expunging the No Liability Claims.

Reservation of Rights

16. LBHI reserves all rights to object on any other basis to any No Liability Claim as to which the relief requested herein is not granted.

Notice

17. No trustee has been appointed in these chapter 11 cases. Notice of this Three Hundred Forty-First Omnibus Objection to Claims has been provided to (i) the United States Trustee for Region 2; (ii) the Securities and Exchange Commission; (iii) the Internal Revenue Service; (iv) the United States Attorney for the Southern District of New York; (v) each claimant listed on Exhibit A; and (vi) all other parties entitled to notice in accordance with the procedures set forth in the second amended order entered on June 17, 2010, governing case management and administrative procedures for these cases [ECF No. 9635]. The Plan Administrator submits that no other or further notice need be provided.

18. No previous request for the relief sought herein has been made by the Plan Administrator or the Chapter 11 Estates to this or any other Court.

WHEREFORE the Plan Administrator respectfully requests entry of an order granting the relief requested herein and such other and further relief as is just.

Dated: August 14, 2012
New York, New York

/s/ Robert J. Lemons
Robert J. Lemons

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Attorneys for Lehman Brothers Holdings Inc.
and Certain of Its Affiliates

EXHIBIT A

IN RE: LEHMAN BROTHERS HOLDINGS INC., ET AL. CASE NO. 08-13555 (JMP)

OMNIBUS OBJECTION 341: EXHIBIT A - NO LIABILITY CLAIMS

	NAME	CASE NUMBER	DEBTOR NAME	FILED DATE	CLAIM #	ASSERTED TOTAL CLAIM DOLLARS	AMOUNT TO BE DISALLOWED	AMOUNT NOT SUBJECT TO THIS OBJECTION	
1	ARMAN, ANNE	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/18/2009	18130	Undetermined	Undetermined		None
2	BARICEVIC, JOANNA M.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/16/2009	13425	Undetermined	Undetermined	PRIORITY	Undetermined
3	BENSON, CRAIG O.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	1/29/2009	2136	$312,864.31	$2,625.64	PRIORITY	$310,238.67
4	BLUM, G KEVIN	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/22/2009	27323	$652,300.00	$652,300.00		None
5	CASTELLANOS, JOSE G	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/22/2009	30045	$1,062.08	$1,062.08		None
6	CHIN, NEVILLE	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/10/2009	11322	$1,319.16	$1,319.16		None
7	GOLDSTEIN, JOSH	08-13555 (JMP)	Lehman Brothers Holdings Inc.	7/2/2009	5070	$421.58	$421.58		None
8	HAMILL,ROBERT B.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	7/15/2009	5345	$1,386.00	$1,386.00		None
9	JENDRUSIAK, KARINA	08-13555 (JMP)	Lehman Brothers Holdings Inc.	8/11/2009	7998	Undetermined	Undetermined	PRIORITY	Undetermined
10	KENNEY, ARTHUR J.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/22/2009	27321	$646,800.00	$646,800.00		None
11	MAHLER, JAY M.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/21/2009	24031	$166,121.59	$4,417.49	PRIORITY UNSECURED	$10,950.00 $150,754.10 $161,704.10

* - Indicates claim contains unliquidated and/or undetermined amounts

IN RE: LEHMAN BROTHERS HOLDINGS INC., ET AL., CASE NO. 08-13555 (JMP)

OMNIBUS OBJECTION 341: EXHIBIT A - NO LIABILITY CLAIMS

	NAME	CASE NUMBER	DEBTOR NAME	FILED DATE	CLAIM #	ASSERTED TOTAL CLAIM DOLLARS	AMOUNT TO BE DISALLOWED	AMOUNT NOT SUBJECT TO THIS OBJECTION	
12	MCCARTHY,ROBERT E.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/4/2009	10413	$208,000.00	$5,000.00	UNSECURED	$203,000.00
13	NASH, ANTHONY A.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	7/23/2009	5942	$20,101.14	$20,101.14		None
14	ORLOSKY, JASON	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/21/2009	26150	$925.60	$925.60		None
15	PETRUCELLI, MICHAEL J.	08-13555 (JMP)	Lehman Brothers Holdings Inc.	7/20/2009	5770	$2,452,214.56	$1,289.86	PRIORITY UNSECURED	$10,950.00 $2,439,974.70 $2,450,924.70
16	REGAN, DONALD HENRY	08-13555 (JMP)	Lehman Brothers Holdings Inc.	9/22/2009	31385	$575,550.00	$575,550.00		None
17	SINER, JASON	08-13555 (JMP)	Lehman Brothers Holdings Inc.	11/6/2008	534	$111,546.99	$7,831.08	PRIORITY UNSECURED	$10,950.00 $92,765.91 $103,715.91
18	TOY, JUDY	08-13555 (JMP)	Lehman Brothers Holdings Inc.	8/13/2009	8187	$668.76	$668.76		None
19	WELCH, MICHAEL GODFREY	08-13555 (JMP)	Lehman Brothers Holdings Inc.	1/29/2009	2127	$115,437.66	$4,729.58	PRIORITY	$110,708.08
				TOTAL		$5,266,719.43	$1,926,427.97		$3,340,291.46

* - Indicates claim contains unliquidated and/or undetermined amounts

EXHIBIT B

2008 Summary Plan Description

Effective: 1 January 2008

Medical, Dental, Vision Care, Flexible Spending Accounts, Life and Disability

Introduction

This booklet is intended to be a Summary Plan Description for the **Lehman Brothers Holdings Inc. Group Benefits Plan** the "Plan"). The Plan includes group medical, dental and vision coverages, flexible spending accounts, life and accident insurance and long and short term disability coverage. You are entitled to a hard copy of this Summary Plan Description free of charge. Active employees may print all or parts of the booklet on Lehman Brothers printers. In addition, participants, beneficiaries, dependents and any of their legal representatives may request a hard copy of this booklet by calling the Lehman Brothers Global HR Service Center (HR Service Center) at 5-2363 (212-526-2363).

This summary plan description summarizes the benefits available to U.S. benefits-eligible employees (see the Who is Eligible for these Benefits section below) and, in the case of the Medical Plan, includes the portion of the Plan document defining the available benefits. ***Your participation and the benefits to which you are entitled under the plan are subject to the terms and provisions of the applicable plan documents and, in the case of a conflict between this booklet and the plan documents, the plan documents will govern.***

In describing your benefits, we have tried to avoid using the technical words and phrases used in the governing legal documents. However, the official legal documents must remain the final authority in the administration of these benefits. You may examine the legal documents by contacting the HR Service Center at 5-2363 (212-526-2363).

Right to Amend or Terminate

Lehman Brothers reserves the right to change or discontinue any of these benefits and programs at any time without prior notice. This includes, but is not limited to, the level of benefits, eligibility for benefits and any cost to participants.

Who Is Eligible for These Benefits

To be a "U.S. benefits-eligible employee" you must be:

- An active employee of Lehman Brothers Holdings Inc., Lehman Brothers Inc. or a participating affiliate (a list of participating affiliates is available from the HR Service Center); and
- A salaried employee, hourly employee or commissioned Investment Representative on the U.S. payroll who is regularly scheduled to work 20 hours or more per week; and
- If you are based outside of the United States, you must be subject to U.S. income and Social Security taxes.

You are not eligible if you are:

- An hourly employee working less than 20 hours per week, or
- An employee on seasonal or temporary assignment or you are employed in a special purpose program (such as student intern), or
- A leased employee, or an employee who performs services for Lehman Brothers under an arrangement in which you are treated as a consultant, an independent contractors or an employee of another entity.

Enrollment

As a new or newly benefits eligible employee, you may elect coverage within 31 days of your date of hire or date of eligibility, whichever is later. If you do not make an election within 31 days of becoming eligible you will only have coverage in the programs that are 100% company-paid. Your next opportunity to enroll in the Medical, Dental, Vision Care and/or Flexible Spending Account plans will be during the annual Open Enrollment period (usually from mid-October through mid-November), for coverage effective the following January 1. If you have a qualified family status change, you may be eligible to elect coverage prior to the Open Enrollment period. See the "Mid-year Changes to Coverage" section for more details.

You may choose a different level of coverage (individual, individual + one, or family) for each Plan. For example, a married employee with a newborn baby may choose "Family" coverage under the Medical Plan (to cover all 3 family members), "Employee Plus One" under the Dental Plan (to only cover the employee and the spouse), and choose to only enroll the spouse in the Vision Care Plan. Please consult the specific plan sections for information on each plan's enrollments rules.

Please review the appropriate section of this document for details on your enrollment opportunities in the programs that are not part of the annual Open Enrollment period.

To enroll, access the e-Benefits Web page within the Benefits section of Lehman & You.

Mid-year Changes to Coverage

Because your Medical, Dental, Vision Care, and Flexible Spending Account plan employee contributions are made on a pre-tax basis, the Internal Revenue Code requires that your coverage election stay in effect throughout the full Plan Year unless you have experienced a "qualified family status change." If you have experienced a qualified family status change, you have 31 days from the qualifying event to change your coverage election. Your change (enrollment, change in coverage type or cancellation) must correspond with the Family Status event.

If one of these events occurs you have 31 days from the date of that event to make a change in your benefit elections. You must contact to the HR Service Center via e-mail at HRServices@lehman.com or fax a memo to the HR Service Center at 646-758-5200. You must include your social security number, the qualifying event and date the event occurred. The HR Service Center will e-mail you a link that will allow you to make your elections online.

The chart on page 5 lists the types of events that may qualify as a family status change and the corresponding coverage changes you can elect. A coverage change must be consistent with the qualified family status change. For example, if your spouse or domestic partner loses medical coverage you may increase your medical coverage level (adding dependents) or enroll for the first time, but you may not decrease your coverage level or cancel coverage. Another example of a coverage change that is consistent with a qualified family change would be if you adopt a child, you may enroll the child and yourself or other family members in the Medical Plan, but you cannot drop coverage or only enroll yourself.

Qualified Family Status Changes

Family Status Change	**Allowable Coverage Changes**
Entering a domestic partnership	• Enrollment of domestic partner
Divorce, legal separation or death of spouse	• Enrollment of employee and/or dependents, if previously covered under spouse's plan • Cancellation of spouse's coverage
Termination of domestic partnership or death of domestic partner	• Enrollment of employee and/or dependents, if coverage under Plan originally declined due to coverage under domestic partner's plan • Cancellation of domestic partner's coverage
Birth or adoption of a child (including initiation of adoption proceedings); legal guardianship of a child	• Enrollment of child • Enrollment of employee/dependents together with child
Spouse becomes unemployed, loses coverage or takes unpaid leave of absence.	• Enrollment of employee, spouse or dependents, if previously covered under spouse's plan
Domestic partner becomes unemployed, loses coverage or takes unpaid leave of absence	• Enrollment of domestic partner, if previously covered under domestic partner's plan • Enrollment of employee or dependents, if coverage under Plan originally declined due to coverage under domestic partner's plan
You take unpaid leave of absence	• Cancellation of all coverage • Decrease your coverage level (e.g. from employee plus one to single coverage level or from family to employee plus one or single)
Dependent child returns to school full-time	• Add coverage for the child
Death of a dependent	• Enrollment of employee and/or dependents, if previously covered under dependent's plan • Cancellation of deceased dependent's coverage
Spouse becomes employed and/or becomes eligible for family coverage	• Cancellation of employee and/or dependent coverage, if coverage obtained under domestic partner's plan
Domestic partner becomes employed and/or becomes eligible for family coverage	• Cancellation of employee, dependent and/or domestic partner's coverage, if coverage obtained under domestic partner's plan

Definition of a Dependent

For the Medical Plan, Dental Plan, Vision Care Plan and Group Term Life Insurance Program, eligible dependents include those listed below. For the Flexible Spending Accounts and Voluntary Group Accident Plan, eligible dependents are defined separately. See the summaries of those plans for details.

- Your legal spouse or domestic partner. A domestic partner is any person who resides with you and with whom you have a currently registered domestic partnership with a governmental body pursuant to state or local law authorizing such registration. In the absence of a formal registration, you can register your domestic partnership by filing a Declaration of Domestic Partnership with the HR Service Center.
- Your unmarried children up to age 19 years if they live with you for more than ½ the year and do not provide more than ½ of their own support, or if you claim them as a dependent on your federal income tax return. (The term "children" includes your own child, legally adopted child, child for whom legal adoption proceedings have been initiated, foster child or child for whom you have been named legal guardian.) Coverage ends December 31, following or coincident with the child's 19th birthday or at the end of the month in which a child graduates, marries or is providing more than ½ of their own support, whichever event occurs first.
- Your unmarried children up to age 24 (25 if you claim them as a tax dependent) if they are enrolled full-time in an accredited institution of higher learning and they do not provide more than ½ of their own support. Eligibility for coverage will cease (a) at the end of the month in which a child graduates, marries, provides over ½ of their own support, or no longer attends school, regardless of age, or (b) for 25 year old children, the end of the month in which you file a federal income tax return that does not claim the child as a dependent, or (c) the December 31 following or coincident with the child's 25th birthday, whichever event occurs first.
- Your unmarried, fully handicapped child, regardless of age, who is totally and continuously disabled and who is incapable of self-sustaining employment by reason of a mental or physical handicap (as approved by Aetna), who does not provide more than ½ of their own support and who lives with you for more than ½ the year, and who became incapacitated prior to attaining the maximum dependent age indicated above. Please contact the HR Service Center at 5-2363 (212-526-2363) for further information. To submit an application to Aetna, two forms must be completed; one by the member and one by the disabled child's physician. Both are to be submitted to Aetna for consideration. Eligibility for coverage will cease when Aetna deems that the child is no longer fully handicapped.

Stepchildren or the children of your domestic partner who meet the above requirements qualify as dependents when they are unmarried and are primarily dependent on you and your spouse or domestic partner for maintenance and support. In addition, you and your spouse or domestic partner must have financial responsibility for the child. If financial responsibility was determined by a court (such as in a divorce action) the decision of the court will govern.

A child of divorced or separated parents will be considered the dependent of both parents regardless of who can claim the tax exemption as long as the parents provide over half of the child's support.

No person can be covered as both an employee and a dependent, and no person may be covered as a dependent of more than one employee.

Whose Plan is Primary?

When both parents are employed and each is covered under a different group medical plan at work, the employer's plan always pays first; that is, your primary plan is the one through your employer and your spouse or domestic partner's primary plan is the one through his or her employer. You may apply through your spouse or domestic partner's plan for secondary coverage and he or she can do the same through your plan, but each must first apply to his or her own group plan. See the "Coordination with Other Group Medical Plans" sections for further information on how secondary coverage works under the Medical Plan. If children are covered under both parents' plans, the determination of primary coverage is not based on a parent's age but on whose birth date falls earliest in the calendar year. For example, if the mother's birth date is January 6 and the father's birth date is July 8, the mother's coverage is primary, regardless of who is older.

For stepchildren or the children of your domestic partner, if there is no court decree specifying whose coverage is primary, the following rules will apply:

- If the parent with custody is not married or does not live with a domestic partner, the custodial parent's medical plan will be the child's primary carrier and the parent without custody will carry secondary benefits.
- If the parent with custody is married or lives with a domestic partner, the medical plan of that parent is primary; the medical plan of the stepparent or domestic partner living with him or her carries secondary benefits and the medical plan of the parent without custody carries tertiary benefits.

Effect of Qualified Medical Child Support Order

If the Plan receives a Qualified Medical Child Support Order (a "QMCSO") that requires you to provide medical coverage for your dependent children, appropriate deductions for such coverage, beginning as of the date specified in the QMCSO, will be taken from your salary. A QMCSO is a court judgment, decree or order that (a) provides for child support relating to health benefits with respect to the child in such plan, and is ordered under state domestic relations law, or (b) enforces a state medical child support law enacted under Section 1908 of the Social Security Act. The Plan Administrator will notify you if a medical child support order has been received and will determine whether such order is a QMCSO.

Insurance Earnings

Definition of Insurance Earnings

The Firm recalculates your Insurance Earnings once each year, on April 1st, using the following:

- Annualized base salary in effect on December 31st of the prior year;
- Eligible bonuses for the prior year's performance paid through February of the current year, including the discounted value of Restricted Stock Units ("RSUs") awarded as part of the bonus; and
- Production compensation paid in the prior year, including the discounted value of RSUs awarded as part of your production compensation.

The Insurance Earnings calculation is based on gross pre-tax earnings prior to any payroll deductions, including deferrals for the Lehman Brothers Savings Plan and your Flexible Spending Accounts.

Insurance Earnings for New Hires

If you are a new hire, your initial Insurance Earnings are calculated automatically when you enroll in benefits within 31 days of your date of hire.

Salaried Employees

Until the April 1 following your date of hire, a salaried employee will have Insurance Earnings equal to their base salary as of their date of hire. Sign-on bonuses are not included in the calculation of Insurance Earnings.

On the April 1 following your date of hire, a salaried employee's Insurance Earnings will be recalculated according to the Insurance Earnings formula for that year. See the Definition of Insurance Earnings section above.

Commissioned Investment Representatives

Until the April 1 following your date of hire, a commissioned Investment Representative's Insurance Earnings will be $100,000.

On the April 1 following your date of hire, a commissioned Investment Representative's Insurance Earnings will be calculated to be the greater of $100,000 or annualized commissions paid during the prior partial calendar year.

For example, a commissioned Investment Representative hired in September 2006 receives commission payments in October, November and December totaling $20,000. Annualized (divide by 3, multiply by 12) commissions are therefore $80,000. Since this is less than $100,000, on April 1, 2007, his or her Insurance Earnings will be remain $100,000 (the initial Insurance Earnings amount for a newly hired commissioned employee).

On the April 1 following the first full calendar year of employment, a commissioned Investment Representative's Insurance Earnings will be recalculated according to the Insurance Earnings formula for that year.

Employment at Will

Your employment is "at will." This means that your employment is for no definite period and can be terminated by you or the Firm for any reason or for no reason at all, with or without notice.

The description of the Plan contained in this Summary Plan Description is for your information. Access to this Summary Plan Description does not create a contract or employment rights and no provisions is a guarantee or a promise of any kind. The Firm may change, supplement, and/or withdraw any or all of the benefits described in this booklet at any time, with or without notice. Accordingly, nothing in this booklet changes your status as an employee "at will."

When Coverage Ends

Generally, your coverage under the Lehman Brothers Group Benefit Plan and/or coverage of your dependents will cease:

- As of midnight on the day your employment terminates or you cease to be a U.S. benefits-eligible employee (see Who Is Eligible for These Benefits); or
- As of midnight on the day a covered dependent no longer meets the definition of an eligible dependent (see Definition of a Dependent); or
- As of the last day of a month when you fail to pay your employee contributions; or
- As of the effective date that you discontinue coverage due to an Open Enrollment election or a "qualified family status change"; or
- When the Plan is terminated by the Firm.

Upon termination of coverage, you and/or your eligible dependents may be entitled to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"). See Continuation of Coverage section for details.

Medical Plan

The ***Lehman Brothers Medical Plan*** is an open choice point of service plan managed by Aetna, a national leader in health care management. Aetna has established a network of carefully selected health care professionals, who have agreed to accept a negotiated fee for their services. Each provider must meet Aetna's strict standards for professional certification and must abide by Aetna's quality control procedures. Once admitted to the network, doctors are continually re-evaluated. Aetna's re-evaluation procedures include patient satisfaction surveys, audits, on-site visits and re-certification every two years.

Under the Aetna Choice POS II you have two levels of benefits. You may use a network health care provider, (referred to as using the "in-network" benefit). Alternately, you may choose to see a health care provider not affiliated with the network (referred to as using the "out-of-network" benefit). You always have the choice to go in- or out-of-network while you are enrolled in the Plan.

Eligibility and Enrollment

If you are a U.S. benefits-eligible employee, you are eligible to enroll in the Medical Plan. Coverage is available for you and your eligible dependents as of the first day of employment provided you enroll within 31 days of hire. Hourly employees whose status changes to U.S. benefits-eligible must enroll within 31 days of the status change.

U.S. benefits-eligible employees based outside of the United States are eligible for the Aetna Global Benefits Medical Plan.

Please note that you must be enrolled in the Medical Plan to enroll your dependent(s).

Late Enrollment/Open Enrollment

Enrollment in the Medical Plan is not automatic. Employees and/or eligible dependents who do not enroll within 31 days of becoming eligible will not be eligible to enroll until the next annual Open Enrollment period (usually from mid-October through mid-November), with an effective date for coverage the following January 1st.

Use of Insurance Earnings under the Medical Plan

Because the Medical Plan employee contributions, deductibles and out-of-pocket maximums are set on January 1 of each year, they are based on Insurance Earnings calculated the prior April 1. Accordingly, although Insurance Earnings are recalculated each year on April 1, your employee contribution, deductible and out-of-pocket maximum will not change until the first day of the following calendar year.

For example if your Insurance Earnings were calculated as follows:

- April 1, 2007 $45,000
- April 1, 2008 $60,000

your 2008 deductible, out-of-pocket maximum and employee contribution are based on the figure calculated in 2007 ($45,000). The figure calculated in 2008 ($60,000) will be used to determine your 2009 deductible, out-of-pocket maximum and monthly employee contribution.

Cost of Coverage

Pre-tax Monthly Employee Contributions

While the Firm pays most of the cost of coverage, you will be asked to pay a portion of the expense. Your monthly contribution, paid on a pre-tax basis, is determined by your Insurance Earnings. If you initially elect to cover yourself and one (1) dependent, you must designate the dependent that will be covered and you may not substitute a different dependent at a later point during the year. If you choose "family" coverage, there is no limit to the number of dependents that can be covered, but all dependent must be enrolled during the Open Enrollment period or within 31 days of your date of hire or a qualified family status change. The chart below details the pre-tax payroll deductions for the calendar year 2008.

Insurance Earnings as of January 1, 2008	Coverage Level		
	Individual	Employee Plus One Dependent	Family (Employee Plus Two or More Dependents)
Under $50,000	$35	$71	$109
$50,000 – 99,999	53	106	164
$100,000 – 149,999	71	141	219
$150,000 – 299,999	88	176	274
$300,000 – 499,999	106	212	328
$500,000 – 749,999	124	247	383
$750,000 and above	141	282	438

Calendar Year Deductibles (Out-of-Network Only)

Before the plan pays benefits for out-of-network medical services, participants must meet a calendar year deductible. Each covered individual must meet his or her calendar year deductible before the Plan begins paying benefits. However, if you have Family coverage, the maximum Family deductible is equal to three times the individual deductible. Expenses applied to the deductible for all family members will be aggregated towards this limit.

Insurance Earnings as of January 1, 2008	Calendar Year Deductible
Under $50,000	$400
$50,000 – 99,999	500
$100,000 – 149,999	600
$150,000 – 299,999	700
$300,000 – 499,999	800
$500,000 – 749,999	900
$750,000 and above	1,000

Once the calendar year deductible has been met, the Plan begins reimbursing out-of-network expenses at 70% of reasonable and customary charges.

Calendar Year Out-of-Pocket Maximums

Once a covered individual has met the calendar year out-of-pocket maximum, the Plan begins to pay benefits at 100% of covered expenses. (Deductibles and copays do not count toward the out-of-pocket maximum.) Separate out-of-pocket maximums apply to in- and out-of-network expenses. Each covered individual must meet an out-of-pocket maximum before the Plan will reimburse at 100% of negotiated costs (in-network) or reasonable and customary charges (out-of-network) for that individual.

Insurance Earnings as of January 1, 2008	**In-Network**	**Out-of-Network**
Under $50,000	$1,000	$2,000
$50,000 – 99,999	1,250	2,500
$100,000 – 149,999	1,500	3,000
$150,000 – 299,999	1,750	3,500
$300,000 – 499,999	2,000	4,000
$500,000 – 749,999	2,250	4,500
$750,000 and above	2,500	5,000

Medical Plan Benefits at-a-Glance

Plan Provision	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	
Precertification of In-Patient Hospitalization	Yes	
Office Visits (Primary Care Physician)	100% after $20 copay[2]	70% after deductible
Office Visits (Specialists)	100% after $30 copay[2]	70% after deductible
Choice of Doctors	Network providers only	Any provider
Claim Forms Required	No	Yes
Hospital Services:		
Semi-Private Room & Board	90%, no deductible	70% after deductible
Surgery (in- or out-patient)	90%, no deductible	70% after deductible
X-rays and other Diagnostic Procedures Billed by the Hospital	90%, no deductible	70% after deductible
Emergency Room	90%, no deductible	90%, no deductible
Short-Term Rehabilitation:		
Includes physical, occupational and restorative speech therapy	100% (after $30 copay[2], if billed as an office visit)	70% after deductible
Benefit Maximum[1]	60 visits per calendar year. Maximum applies to any combination of Outpatient physical, occupational and speech therapy.	
Speech Therapy for Developmental Delays:	Paid as an out-of-network expense: 70% after deductible, in- and out-of-network	
Benefits Maximum[1]	30 visits per calendar year	
Chiropractor	90%, no deductible	70% after deductible
Benefit Maximum[1]	30 visits per calendar year	
Preventive/Wellness Care:		
Routine Physical	100%	70% after deductible
Well-woman Ob/Gyn	100%	70% after deductible
Well-Child Care	100%	70% after deductible
Routine Hearing Exam	100%	70% after deductible
Routine Eye Exam	100%	70% after deductible

Medical Plan Benefits at-a-Glance (continued)

Plan Provision	In-Network	Out-of-Network
Mental Health/Substance Abuse Benefits:		
In-Patient	90%, no deductible[3]	70% after deductible[3]
Benefit Maximum[1]	30 days per calendar year	
Out-Patient	100% after $30 copay per visit	70% after deductible[3]
Benefit Maximum[1]	50 visits per calendar year	
Prescription Drugs:		
Retail Pharmacy	100% after coinsurance, maximum $100 Generic: 10% coinsurance Preferred Brand: 25% coinsurance Non-Preferred Brand: 50% coinsurance	Reimbursement will be at the same amount as if prescription was filled at an in-network pharmacy. (See Prescription Drug section for an example)
Mail Order Pharmacy[4]	100% after coinsurance, maximum $250 Generic: 10% coinsurance Preferred Brand: 25% coinsurance Non-Preferred Brand: 50% coinsurance	Not Covered
Maternity Care:		
Prenatal Doctor Visits	100%	70% after deductible
Doctor's Charge for Delivery	90%, no deductible	70% after deductible[5]
Hospital Charges (semi-private room & board)	90%, no deductible	70% after deductible[5]
Pediatrician (in-hospital)	90%, no deductible	70% after deductible[5]
Infertility Treatment:		
Pre-authorization of treatment plan required	Covered as any other medical service: copays apply to office visits; 90% and 70% coverage for other services	
Benefit Maximum[1]	All covered infertility services and prescription drugs are applied towards a $15,000 infertility treatment lifetime maximum.	

[1] All maximums apply to the combination of in- and out-of-network benefits.
[2] In-network copays do not count toward out-of-pocket maximum.
[3] Mental health coinsurance does not count towards out-of-pocket maximum.
[4] Mail Order Prescription drug coverage is *only* available through the Medco Mail Order Drug Program.
[5] Mother and baby must *each* meet deductible.

If Your Doctor Leaves the Network

Because your employee contributions are made on a pre-tax basis, the Internal Revenue Code requires that your election remain in effect through the end of the tax year. If your primary care physician decides to leave the network, you can continue to be treated by him or her and utilize the out-of-network benefits. If you wish to utilize in-network benefits, you will need to change to an in-network physician. You will not be permitted to cancel your Medical Plan enrollment until the next Open Enrollment period, with the cancellation being effective the following January 1st.

Reasonable and Customary Charges

Out-of-network benefits are reimbursed at 70% of "reasonable and customary" expenses. The reasonable and customary charge for a service or supply is the lower of:

- The provider's usual charge for furnishing it; or
- The charge Aetna determines to be the prevailing charge level made for that service or supply in the geographic area where it is furnished.

In determining the reasonable and customary charge for a service or supply that is unusual or not often provided in your area, or provided by only a small number of providers in your area, Aetna may take into account factors such as: complexity of the procedure, degree of skill needed, type of specialty of the provider, range of services or supplies provided by a facility and the prevailing charge in other areas.

Example of Reasonable and Customary Limit

- Your out-of-network physician charges $300 for a specific procedure.
- If Aetna determines that the reasonable and customary limit for that procedure is $200.
- The difference ($100) is not a covered expense under the Plan; it is not reimbursable and does not count toward your deductible or out-of-pocket maximum.
- The reasonable and customary portion of the expense ($200) is a covered out-of-network expense, reimbursable at 70% ($140) after you have met your calendar year deductible.

Pretreatment Review

You or your doctor should contact Aetna before any major out-of-network treatment begins to determine the reasonable and customary charge for that procedure. Contact Member Services at (800) 345-4432 to obtain a "pretreatment estimate" for any procedure.

Medical Necessity

In order for an expense to be covered, it must be determined by Aetna to be medically necessary. A service or supply furnished by a particular provider is deemed medically necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or the injury involved.

To be considered appropriate, the service or supply must be:

- Care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative care or treatment, both as to the disease or injury involved and the person's overall health condition; or
- A diagnostic procedure, indicated by the health status of the person, as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative diagnostic procedure, both as to the disease or injury involved and the person's overall health condition.

In addition, the service or supply must cost no more (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining whether a service or supply is appropriate under the circumstances, Aetna will take into consideration information provided on the affected person's health status, reports in peer-reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment, the opinion of health professionals in the generally recognized health specialty involved and any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional.
- Those furnished mainly for the personal comfort or convenience of the patient, any person who cares for the patient, any person who is part of the patient's family, or any health care provider or health care facility.
- Those furnished solely because the person is an in-patient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined.
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Maximum Lifetime Benefits

There is no lifetime maximum under the Lehman Brothers Medical Plan except that associated with infertility treatment benefits.

Aetna Member Services

Member Services at Aetna consists of a team of professionals who are available to provide network information and answer any questions you may have about your coverage.

You can reach Member Services by calling (800) 345-4432 from 8:00 a.m. to 6:00 p.m., Monday through Friday, Eastern Standard Time.

Call Member Services to:

- Obtain information about network providers in your area (e.g., availability, location, office hours);
- Register comments about network providers;

- Find out about network facilities and services; and
- Ask questions about plan features and procedures.

Coverage While Traveling

If you or your covered dependents need medical care while traveling on a vacation or business trip outside the network area, the Plan will provide coverage as follows:

- If you have a medical emergency[1], get treatment immediately. Then notify Aetna within 48 hours.
- If you have a minor illness (e.g., cold or flu), you can call Aetna for a referral to an in-network physician in the area.

Coordination of Benefits with Other Group Medical Plans

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits (see the Non-Duplication of Benefits section). For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person as the primary enrollee (e.g. as an employee) will be deemed to pay its benefits before a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary as a result of the Social Security Act of 1965, as amended:
    - If the covered individual is a U.S. benefits-eligible employee who is still actively at work (e.g. not on long term disability or COBRA) or a dependent of such an individual, Medicare will be considered secondary to the Lehman Brothers Medical Plan.
    - If the covered individual is not a U.S. benefits-eligible employee who is still actively at work (e.g. on long term disability, COBRA or a retiree) or a dependent of such an individual, Medicare will be considered primary to the Lehman Brothers Medical Plan.

    The only exception to the above Medicare rule is that once a covered person has had end stage renal disease (ESRD) for 33 months Medicare will be considered primary to the Lehman Brothers Medical Plan until 36 months following a successful kidney transplant operation, even if they are still actively at work (or a dependent of an employee that is actively at work).
3. Except in the case of a dependent child whose parents are divorced or separated; if a dependent child is covered under multiple plans, the plan of the parent whose birthday comes first in a calendar year will be primary. For example, if the father was born on August 1st and the mother was born on July 1st, the mother's plan will be primary, even if the father is older than the mother. If both parents have the same birthday, the primary plan will be determined by which parent has had coverage under their

[1] For the definition of medical emergency, see the Emergency Care section.

plan for a longer period of time. For example, if the father has been covered under his plan for 5 years and the mother has been covered under her plan for 3 years, the father's plan will be considered primary.

If the other plan does not have a rule similar to the one described in this provision (3), but instead it has a rule based on the gender or age of the parent, the rule of the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in provision (3) will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, that parent's plan will be considered primary.
   c. If there is no such court decree:
      - If the parent with custody of the child has not remarried, that parents' plan will be considered primary and the plan of the parent without custody will be considered secondary..
      - If the parent with custody of the child has remarried, that parent's plan will be considered primary, their spouse's plan will be considered secondary and the plan of the parent without custody will be considered tertiary.
5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers a primary enrollee who is a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

   If the other plan does not have a provision regarding laid-off or retired employees and as a result, the plans disagree on which plan should be primary, then the above paragraph will not apply.

   The benefits of a plan which covers the person under a right of continuation of benefits pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation. If the other plan does not have a provision regarding right of continuation pursuant to federal or state law and as a result, the plans disagree on which plan should be primary, then this paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored determining the amount that will be reimbursed.

Aetna may release or obtain data in order to administer this provision or to make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limits of this Plan.

Definition of "Other Plan"

The term "other plan" means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Non-Duplication of Benefits

If your spouse and/or dependents are covered by another group medical plan, full in-network benefits are only available if coverage under the Lehman Brothers Medical Plan is primary. In-network benefits may be available for certain services (such as preventive care) that are not covered under the primary plan. Please call Member Services at 800-345-4432 to verify what might be covered under the Lehman Brothers Medical Plan as secondary coverage.

Out-of-Network benefits are available as secondary coverage in accordance with the Lehman Brothers Medical Plan's "non-duplication of benefits" provision. The non-duplication of benefits provision applies if you or a covered dependent are eligible to receive benefits from more than one group medical plan. Benefits paid under any other group medical plan or under a no-fault insurance policy will be deducted from the out-of-network benefits the Lehman Brothers Medical Plan would otherwise pay, and this Plan will pay the difference, but only up to the amount that would have been paid as out-of-network benefits under the Lehman Brothers Medical Plan. If payment received from the other plan is equal to or greater than the amount of out-of-network benefits the Lehman Brothers Medical Plan would have paid, you will not receive payment under this Plan.

For example: Assume you work for Lehman Brothers and your spouse works for another company and both of you have coverage through your respective employers' plans. Your spouse visits a doctor who is not in the Aetna network and incurs covered expenses of $100. Your spouse then receives $80 from his or her medical plan. Assuming your spouse's deductible had already been met, the Lehman Brothers Medical Plan would not pay the $20 balance, because $70 is the maximum out-of-network benefit the Lehman Brothers Medical Plan would have paid.

If your spouse's deductible has not been met, and is greater than your out-of-network deductible, then the Lehman Brothers Medical Plan will recognize as an out-of-network covered expense any amount in excess of this Plan's deductible, provided the expenses were credited against the deductible of your spouse's plan and are reasonable and customary (see the "Reasonable and Customary Charges" section for details).

Physicians

Primary Care Physicians

Although you are not required to designate a primary care physician under the Lehman Brothers Medical Plan, it is recommended that you consult one for most of your medical needs. Internists, general practitioners, family practitioners and pediatricians are considered primary care physicians. The following are tips on choosing an in-network primary care physician:

- Find out if your current doctor is in the Aetna network by checking your provider directory or by calling the physician's office.
- Decide what type of physician you want for yourself and each of your covered dependents (i.e., internist, family practitioner, general practitioner or pediatrician).
- Using the provider directory, make a list of all the doctors in each category who appeal to you. Consider the following criteria:
  - Is the doctor located close to your home or office (whichever is more convenient for you)?
  - Is the doctor affiliated with the network hospital you prefer to use?
  - Ask people you know if they have had experience with any of the doctors on your list. You can also call your current physician for a recommendation.
- Call or visit the office and talk with the doctor's staff. Find out about office hours, emergency procedures, how long you have to wait for an appointment, medical services available when the doctor is out of town, and other issues that matter to you.

In-Network Benefits

Services received from an in-network primary care physician are 100% covered for preventative and wellness care. Other services from an in-network primary care physician are covered at 100% after a $20 copay. Services received from an in-network lab or facility, all tests and laboratory fees are covered by the Plan at 100% with no copay. In-hospital doctors' visits and services are covered at 90% of the negotiated network cost.

Out-of-Network Benefits

If you choose to consult a non-network primary care physician, covered expenses will be reimbursed under the out-of-network provision: after you meet your annual deductible, the Plan reimburses at 70% of reasonable and customary charges.

Specialists

The Aetna network is composed of specialists in all medical fields who have agreed to provide services for Plan participants.

In-Network Benefits

You do not need a referral from a primary care physician in order to be eligible for in-network benefits. Services received from an in-network specialist are 100% covered for preventative and wellness care. Other services from an in-network specialist are covered at 100% after a $20 copay. Services received from an in-network lab or facility, all tests and laboratory fees are covered by the Plan at 100% with no copay. In-hospital doctors' visits and services are covered at 90% of the negotiated network cost.

Out-of-Network Benefits

If you choose to consult a non-network specialist, covered expenses will be reimbursed under the out-of-network provision: after you meet your annual deductible, the Plan reimburses at 70% of reasonable and customary charges.

Precertification of Hospital Stays and Outpatient Procedures

You or your physician must call Aetna in advance to "precertify" the following:

- All non-emergency hospital admissions,
- Treatment in skilled nursing home facilities,
- Care from home health care agencies and hospices, and
- Outpatient surgical procedures performed at a hospital or surgical center

Certification of days can be obtained as follows:

If the admission is a non-urgent admission, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency admission or an urgent admission, you, the person's physician, or the hospital must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an urgent admission; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the physician, it is necessary to be confined for a longer time than already certified, you, the physician or the hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

If you or your covered dependent becomes confined in a hospital as a full-time patient and Aetna has not certified that such hospitalization is necessary and the hospitalization has not been ordered and prescribed by a physician, covered medical expenses incurred on any day not certified will be paid as follows:

For Hospital Expenses incurred during the confinement:

- If certification has been requested and denied:
  - No benefits will be paid for Hospital Expenses incurred for board and room.
  - Benefits for all other Hospital Expenses will be paid in accordance with the Plan benefits.
- If certification has not been requested and the confinement (or any day of such confinement) is not necessary:
  - No benefits will be paid for Hospital Expenses incurred for board and room.
  - As to all other Hospital Expenses:
    - Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
    - Benefits for such expenses in excess of the Excluded Amount will be paid in accordance with Plan benefits.

- If certification has not been requested and the confinement (or any day of such confinement) is necessary:
  - Hospital Expenses incurred for board and room, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
  - Benefits for all other Hospital Expenses will be payable in accordance with Plan benefits.
  - As to other Covered Medical Expenses:
    - Benefits will be paid in accordance with Plan benefits.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not necessary will not be applied to expenses for hospital room and board.

In-Network Benefits

Your in-network physician (primary care physician or specialist) will arrange all necessary precertification for in-network benefits.

Out-of-Network Benefits

Ultimately, you and your doctor decide what treatment you will receive. The Plan determines the level of benefit reimbursement.

Covered Expenses/Plan Benefits

This Summary Plan Description contains general, summarized descriptions of benefits available under the Lehman Brothers Medical Plan. A partial list of expenses not covered under the Lehman Brothers Medical Plan can be found in the Expenses Not Covered section. Copies of the underlying Plan document, with schedules of benefits and exclusions, are available at no charge from the HR Service Center.

Preventive Care/Wellness Benefits

The Medical Plan provides for preventive care benefits on both an in- and out-of-network basis.

Routine Physicals

The Lehman Brothers Medical Plan provides for routine physical examinations, regardless of whether you have been ill or injured, according to the following schedule:

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Well-Baby and Well-Child Care

Under the Lehman Brothers Medical Plan, your dependent children are covered for all well-baby and well-child visits.

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Gynecological Examinations

In addition to the routine physicals described above, the Medical Plan covers all routine gynecological exams.

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Mammography

In addition to medically necessary mammography, the Lehman Brothers Medical Plan covers all routine mammograms.

In-Network: The Plan covers 100%.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Male Cancer Screening

In addition to medically necessary cancer screening, men age 40 and older are covered for routine digital rectal exams and laboratory fees for Prostate Specific Antigen.

In-Network: The Plan covers 100%

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Eye Exam

Covered Medical Expenses include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist to a person.

The following types of eye exams are not covered under the Plan:

- an eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses;
- drugs or medicines;
- any services or supplies which are included as covered expenses under any other benefit section included in this Plan or under any other plan of group benefits provided through the Firm (such as the Lehman Brothers Vision Care Plan);
- any service or supply which does not meet professionally accepted standards;
- any exams given while the person is confined in a hospital or other facility for medical care

In-Network. The Plan covers 100%.

Out-of-Network. The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Hearing Exam

Covered Medical Expenses include charges for an audiometric exam.

The services must be performed by a physician certified as an otolaryngologist or otologist or an audiologist who either is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The following types of hearing exams are not covered under the Plan:

- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply which does not meet professionally accepted standards;
- any exams given while the person is confined in a hospital or other facility for medical care.

In-Network. The Plan covers 100%

Out-of-Network. The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Routine Foot Care

Services of a podiatrist are covered for the treatment of a disease or injury, including but not limited to treatment of corns, calluses, keratoses, bunions, and ingrown nails. Aetna does not consider pedicure services, such as routine cutting of nails, in the absence of disease of nails, as medically necessary treatment of disease.

In-Network. The Plan covers 100% after a $30 copay.

Out-of-Network: The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Simple Steps To A Healthier Life

Simple Steps To A Healthier Life® is an interactive online health and wellness program that can help you improve or maintain your health in ways that fit your lifestyle. The program takes you step-by-step to help you achieve your health goals. You and your eligible family members will be able to identify some of your health needs, receive a tailored Health Report and a personalized Action Plan, and participate in recommended Healthy Living Programs. More information is available at www.simplestepslife.com or on Aetna Navigator at www.aetna.com under the section marked ‘Take Action on Your Health.’

MedQuery

The MedQuery[SM] program identifies opportunities for improved care and delivers specific, evidence-based treatment guidelines to physicians.

The program applies over 700 clinical algorithms to identify potential errors, omissions or commissions in your care and the care provided to your eligible family members. The specific opportunities are then communicated to your treating physician according to evidence-based medical research. After your physician is notified, you will also receive a letter, called a 'Care Consideration' advising you of this opportunity for improved care and avoidance of adverse health events.

As medical care becomes more and more complex, and patients are treated by an increasing number of highly specialized physicians, the use of computerized systems to identify opportunities to improve care and prevent error become ever more important.

While all treatment decisions are ultimately the responsibility of the physician in consultation with you, their patient, MedQuery serves as a valuable resource in prompting a doctor to consider aspects of your care that they might otherwise have overlooked.

Aetna Health Connections (for Nebraska Members)

Lehman Brothers, in conjunction with your medical plan, and Aetna are dedicated to improving your knowledge of and control over your own health care. With this in mind, we are pleased to announce an expanded, called Informed Care Management (ICM).

Aetna Health Connections is a free, voluntary program offered through Aetna to provide you and your eligible family members with personalized information about your health. For specific health conditions, you will have the opportunity to work one on one with a Nurse Care Manager who acts as your "personal health coach". The program has been proven to help many people with specific health conditions, like asthma or diabetes, to better manage their health and take active steps to work with their doctors to improve their care. Your health information and participation in this program is confidential.

Your Nurse Care Manager or "personal health coach" will:

- Help you better understand your health condition
- Review your health information with you and prepare a list of questions for you to ask your doctor
- Identify ways for you to take control of your health
- Provide you with information about treatment options, which you can discuss with your doctor

If you are contacted by Nurse Care Manager, we strongly encourage you to take advantage of the program.

Benefits for Medical Illness or Injury

The Lehman Brothers Medical Plan provides coverage for medical illness and injury under both in-network and out-of-network benefits.

In-Network

If you (or a covered dependent) become ill or are injured, contact your primary care physician for an office visit. If you require the services of a specialist, your primary care physician can refer you to an in-network specialist or you may select any in-network specialist from the Aetna provider directory. The cost to you is $20 for each office visit to a primary care physician; $30 for each office visit to a specialist.

Out-of-Network

The Lehman Brothers Medical Plan provides out-of-network coverage for medical illness and injury in much the same way as a typical major medical plan. After you meet your annual deductible, the Plan reimburses 70% of covered expenses until you reach your annual out-of-pocket maximum, after which the Plan reimburses covered expenses at 100%. See the charts for deductible and out-of-pocket maximum amounts.

Only expenses which are deemed medically necessary by Aetna are eligible for reimbursement under the out-of-network benefits. In addition, only that portion of a charge that is determined by Aetna to be reasonable and customary is covered. See the Reasonable and Customary Charges and the Medical Necessity sections for details.

Hospital Expenses

Expenses for the following are covered under the Lehman Brothers Medical Plan when they are provided for medical illness or injury:

- Hospital room and board in a semiprivate room.
- Operating room, recovery room and equipment.
- Drugs, medications and dressings.
- Oxygen.
- Intensive care.
- Laboratory tests.
- Emergency room treatment (see the Emergency Care section for details).

All non-emergency hospitalizations must be precertified, and all emergency hospitalizations must be certified by Aetna. See the Precertification of Hospital Stays and Out-Patient Procedures section for details.

In-Network

In-network hospital expenses are covered at 90% of the negotiated network cost until you have met your in-network calendar year out-of-pocket maximum. Thereafter, coverage is provided at 100% of the negotiated network cost.

Out-of-Network

Out-of-network hospital costs are covered at 70% of reasonable and customary charges, after you have met your calendar year deductible. Once you reach your out-of-network calendar year out-of-pocket maximum, coverage is provided at 100% of reasonable and customary charges.

Treatment by an Urgent Care Provider

You should not seek medical care or treatment from an Urgent Care Provider if your illness; injury; or condition; is an emergency condition. Please go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.

Urgent Care

This Plan pays for the charges made by an Urgent Care Provider to evaluate and treat an urgent condition.

When travel to an Urgent Care Provider for treatment of an urgent condition is not feasible, such treatment may be paid at the in-network level of benefits. If a claim for treatment of an urgent condition is paid at the out-of-network level and you believe that it should have been paid at the in-network level, please contact Members Services at the toll-free number on your I.D. card.

Non-Urgent Care

Covered Medical Expenses for charges made by an Urgent Care Provider to treat a non-urgent condition will be paid on the same basis as those made by an out-of-network Urgent Care Provider .

Non-urgent care includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

Outpatient Surgical Expenses

Covered Medical Expenses include charges for outpatient surgical expenses to the extent shown below. Covered Medical Expenses include charges made:

- on its own behalf by:
  - a surgery center;
  - the outpatient department of a hospital; or
  - an office based surgical facility of a physician or a dentist.
- by a physician;
- on behalf of a salaried staff physician by the outpatient department of a hospital.

For Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a hospital, the procedure must meet these tests:

- It is not expected to:
  - result in extensive blood loss;
  - require major or prolonged invasion of a body cavity; or
  - involve any major blood vessels.
- It can only be performed safely and adequately in a surgical center, in a hospital, or in an office based surgical facility of a physician or a dentist.
- It is not normally performed in the office of a physician or a dentist.

Outpatient Services and Supplies are:

- Services and supplies furnished by the surgery center or by a hospital on the day of the procedure.
- Services of the operating physician for performing the procedure and for:
  - related pre and postoperative care; and
  - the administering of an anesthetic.
- Services of any other physician for related postoperative care and for the administering of an anesthetic. This does not include a local anesthetic.

Limitations:

No benefit is paid for charges incurred:

- For the services of a physician who renders technical assistance to the operating physician.
- While the person is confined as a full-time inpatient in a hospital.

Multiple Surgery or Bilateral Procedures

In-Network

For procedures performed by an in-network provider, the first procedure is paid at 100%, the second or opposite side procedure at 50%, and any subsequent procedures at 25%. In-network providers accept Aetna negotiated rates and may not balance bill you. In-network deductible and coinsurance applies.

Out-of-Network

Multiple Surgeries. When an out-of-network surgeon performs more than one eligible procedure on the same patient during the same operative session, Aetna calculates the allowable benefit as follows:

- 100% of reasonable and customary rates for the first procedure. Out-of-network deductible and coinsurance applies.
- 50% of reasonable and customary rates the second procedure. Out-of-network deductible and coinsurance applies.
- 25% of reasonable and customary rates for each subsequent procedure. Out-of-network deductible and coinsurance applies.

Bilateral Procedures. A surgical procedure is considered bilateral when the same procedure is performed on both sides of the body. Common anatomical sites for bilateral surgical procedures are

extremities, eyes, ears, and breasts. When a surgeon performs bilateral surgery, or a combination of both bilateral and multiple surgery, Aetna calculates the allowable benefit for the eligible procedures in the same manner as for multiple surgery:

- 100% of reasonable and customary rates for the first procedure. Out-of-network deductible and coinsurance applies.
- 50% of reasonable and customary rates the second procedure. Out-of-network deductible and coinsurance applies.
- 25% of reasonable and customary rates for each subsequent procedure. Out-of-network deductible and coinsurance applies.

Incidental surgeries are not reimbursed if billed separately (a procedure that is performed at the same time as a primary procedure, which requires little additional physician resources and/or is clinically and integral part of the performance of the primary procedure).

Gastric Bypass Surgery

In order to qualify for coverage of gastric bypass surgery, you must provide documentation demonstrating that morbid obesity has persisted for 5 years or more and that physician-supervised diet and exercise programs have not been effective.

Morbid obesity is defined as a body mass index (BMI) of 40 or higher; or a BMI of 35 or higher with other medical conditions such as heart disease, diabetes, obstructive sleep apnea and/or hypertension (blood pressure greater than 140 systolic or 90 diastolic).

In addition to documentation regarding morbid obesity, you will need to provide documentation of either A or B below. Note: A physician's summary letter, without evidence of oversight, is not sufficient documentation for criteria A or B.

A. Nutrition and exercise program, with behavioral modification, with all of the following:

   a. Physician-supervised with dietitian consultation; and
   b. Of 6 months duration, with at least 3 months consecutive; and
   c. Within 2 years of surgery; and
   d. Documented in the medical record by the physician supervising participation.

OR

B. Multidisciplinary pre-surgical regimen for at least 3 months with all of the following:

   a. Documentation in the medical record, including physician's initial assessment and progress at completion; and
   b. Diet program including nutritionist supervision; and
   c. Exercise regimen (unless contraindicated) to improve pulmonary reserve, supervised by a qualified professional; and
   d. Behavior modification supervised by a qualified professional.

Skilled Nursing Facility (Convalescing)

Charges for inpatient convalescent care in a skilled nursing facility are covered for a maximum of 120 days per calendar year. All skilled nursing facility care must be pre-certified by Aetna. See the Precertification of Hospital Stays and Out-Patient Procedures section for details.

Covered charges include the following:

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily board and room in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a convalescent facility. This does not include private or special nursing, or physician's services.
- Medical Supplies.

Benefits will be paid for no longer than 120 days during any one calendar year.

Not included are charges made for the treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

In-Network

The Plan covers 90% of the negotiated network cost for a semi-private room until you have met your in-network calendar year out-of-pocket maximum. Thereafter, the Plan covers 100% of the negotiated network cost.

Out-of-Network

The Plan will reimburse 70% of reasonable and customary charges for a semi-private room after you have met your calendar year deductible. Once you have met your out-of-network calendar year out-of-pocket maximum, the Plan will reimburse 100% of reasonable and customary charges.

Skilled Nursing Care Expenses

The charges made by a R.N. or L.P.N. or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by a R.N. or L.P.N. or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a R. N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of 70 shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing services" is:

- that part or all of any nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a hospital or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:
  - for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:
    - change in patient medication;
    - need for treatment of an emergency condition by a physician, or the onset of symptoms indicating the likely need for such services;
    - surgery; or
    - release from inpatient confinement; or
- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a home health care agency; and
- the care is given under a home health care plan; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
  - medical supplies;
  - drugs and medicines prescribed by a physician; and
  - lab services provided by or for a home health care agency.

The following charges are not covered:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you or who is a member of your or spouse/domestic partner's family.
- Services of a social worker.
- Transportation.

Home health care is covered at 90% of the negotiated network cost.

Out-of-network home health care is covered at 70% of reasonable and customary charges after you have met your calendar year deductible.

Hospice Care

Charges made for the services furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Medical Expenses.

These covered services include charges made by a hospice facility, hospital, or convalescent facility for inpatient care including:

- Board and room
- other services and supplies furnished while a full-time inpatient for:
  - pain control; and
  - other acute and chronic symptom management.

Any charge for daily board and room in a private room over the Private Room Limit is not covered under the Plan. In addition, any day of confinement in excess of the 60 day Hospice Care maximum is not covered under the Plan.

Covered charges made by a Hospice Care Agency for services and supplies furnished to a person on an out-patient basis are as follows:

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day.
- Medical social services under the direction of a physician. These include:
  - assessment of the person's:
    - social, emotional, and medical needs; and
    - the home and family situation;
  - identification of the community resources which are available to the person; and
  - assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Bereavement counseling.
- Consultation or case management services by a physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a physician.
- The following charges made by a provider of Outpatient Care are only covered if the provider is not an employee of a Hospice Care Agency that retains responsibility for the care of the patient.
- A physician for consultant or case management services.
- A physical or occupational therapist.
- A Home Health Care Agency for:
  - physical and occupational therapy;
  - part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;
  - medical supplies;
  - drugs and medicines prescribed by a physician; and
  - psychological and dietary counseling.

The Hospice Outpatient Maximum of $25,000 will apply to all Hospice Care Expenses incurred; including inpatient care expenses and expenses incurred while the person is not confined as a full-time inpatient.

Covered expenses under the Hospice Care provisions of the Plan do not include:

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling; including estate planning and the drafting of a will.
- Homemaker or caretaker services. (These are services which are not solely related to care of the person; including sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.)
- Respite care. (This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.)

In-Network

Hospice care is covered at 90% of the negotiated network cost.

Out-of-Network

Hospice care is covered at 70% of reasonable and customary charges after you have met your calendar year deductible.

Medical Services and Supplies

Expenses for the following are covered under the Lehman Brothers Medical Plan when they are provided for medical illness or injury:

- Physicians' fees for home or office visits.
- Consultation charges made by your attending physician or specialist.
- Operations and other surgical procedures on an in-patient basis, or as an out-patient at a hospital (or other licensed medical facility), or in your doctor's office.
- Administration of anesthesia.
- X-ray treatment by a radiologist.
- Lab tests to diagnose or treat your condition.
- Professional ambulance service to and from the nearest hospital where treatment can be rendered. Both the ambulance service and the medical treatment must be "medically necessary."
- Pre-admission testing performed before admission to the hospital.
- Surgical procedures performed in an independent ambulatory surgical facility (sometimes called a short procedure unit or surgicenter).
- Second surgical opinions.
- Home health care.
- Acupuncture performed by a state-licensed Medical Doctor or acupuncturist certified by the American Association for Acupuncture and Oriental Medicine who is practicing within the laws of the jurisdiction where treatment is given.

Benefits are paid at either in-network or out-of-network levels according to provider's participation in the Aetna Choice POS II network..

Emergency Care

A "medical emergency" is a sudden and unexpected change in a person's physical or mental condition that is severe enough to require immediate hospital-level care. Examples include unconsciousness, severe difficulty breathing, poisoning, heart attack and serious bleeding. If you are unsure whether a situation qualifies as an "emergency" as defined above, call your primary care physician first. (All network doctors are required to provide 24-hour telephone coverage.) ***Use of an emergency room for a non-emergency is not covered under the Plan; you will be responsible for the entire charge.***

Emergency care is considered an in-network expense, regardless of the hospital's affiliation. Your cost for the treatment will be a 10% of reasonable and customary expenses, whether the hospital is in- or out-of-network.

Penalty for Not Certifying Emergency Admission

If you do not contact Aetna to certify an emergency admission within 48 hours from the time you are admitted to the hospital, you may be required to pay an additional $400 under the Hospital Precertification clause of this Plan, as described in the Precertification of Hospital Stays and Out-Patient Procedures section.

Gynecological Care

A female participant in the Lehman Brothers Medical Plan (employee, spouse or dependent) may contact any network obstetrician/gynecologist to obtain the following covered services:

- Routine gynecological exams.
- Any necessary follow-up care.
- Acute or long-term gynecological care services.
- Services related to pregnancy.
- Necessary hospitalization.

Covered procedures include tubal ligation and abortion.

Reconstructive Surgery Following Mastectomy

When a covered individual receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the Plan will cover:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy including lymphedema.

Maternity

In addition to the following medical benefits, employees (or their spouses) enrolled in the Lehman Brothers Medical Plan are entitled to participate in a prenatal program. See the Moms to Babies Prenatal Program section below for details about the program and information on how to register.

You may change your coverage level under the plan (e.g. from individual plus one to family coverage) within 31 days after your baby(ies) is(are) born. See the Mid-Year Changes to Coverage section for details. **However, even if you already have family coverage under the plan you must contact the HR Service Center to enroll your baby(ies) in the plan within 31 days of your baby(ies) birth.**

In-Network Maternity Benefits

The Lehman Brothers Medical Plan provides the following in-network maternity benefits:

For the mother: You may choose any network obstetrician. You will pay one $30 copay for the first prenatal office visit to your network obstetrician. Subsequent prenatal obstetric visits with the same physician for the same pregnancy are covered at 100%. Your cost for your (or your spouse's) hospital stay will be 90% of the negotiated network cost.

For the baby: Provided that you elect to cover the newborn(s) under this Plan, your cost for the newborn's(s') hospital services will be 90% of the negotiated network cost (subject to the Coordination of Benefits provisions described in Whose Plan is Primary and Coordination with Other Group Medical Plans).

Out-of-Network Maternity Benefits

If you choose to see an out-of-network obstetrician, you will be reimbursed for 70% of reasonable and customary expenses, after you meet your calendar year deductible, up to your out-of-network calendar year out-of-pocket maximum. (See the charts for deductible and out-of-pocket maximum amounts.) Provided that you elect to cover the newborn(s) under this Plan, charges for the newborn's(s') hospital stay and in-hospital care will also be covered expenses (subject to the Coordination of Benefits provisions described in Whose Plan is Primary and Coordination with Other Group Medical Plans). Both the mother and the baby(ies) will have to meet a deductible, unless your family has already met the maximum Family deductible for the current calendar year.

Maternity Hospital Length of Stay

The hospital length of stay for both the mother and the newborn child will not be restricted to less than 48 hours following vaginal delivery or less than 96 hours following delivery by cesarean section. However, your length of stay may be shorter if your attending provider (i.e. your physician, nurse midwife or physician assistant), after consultation with you, discharges you or your newborn child earlier.

Moms-to-Babies Prenatal Program

The Aetna Moms-to-Babies Maternity Management Program provides women with services, information and resources throughout their pregnancies. The program provides early risk identification, care coordination by obstetrical nurses and support.

You are automatically enrolled in the Moms-to-Babies Maternity Management Program when your obstetrical care providers notify Aetna, generally after the first prenatal care visit. You may also enroll yourself in the program by calling 1-800-CRADLE-1 (1-800-272-3531).

Moms-to-Babies participants have access to the following:

- Women's health obstetrical nurses, who help coordinate your care with participating obstetrical care providers.
- Extensive educational information on prenatal care, labor and delivery, newborn and baby care, postpartum depression, breastfeeding and other pregnancy-related health issues.

- A pregnancy risk survey to help identify potential risk factors and complications.
- Personalized care coordination by experienced obstetrical nurses if the you identify factors that indicate you are high risk.
- Specialized educational information, "For Dad or Partner."
- Breastfeeding support program.
- A preterm labor and delivery program for women in specific at-risk populations (including those with history of preterm labor). The program includes educational information focusing on the risks of premature labor and delivery, nurse visits and telephone follow-up and outreach.

Members can also participate in Aetna's Smoke-free Moms-to-be™ smoking cessation program. The program encourages pregnant women who smoke more than five cigarettes per day to quit smoking during pregnancy. The program is nicotine-free and includes an educational booklet that describes the risks associated with smoking during pregnancy, strategies to help you quit smoking, a relaxation audiotape and inspirational video, and an imitation cigarette to be used to satisfy oral needs.

Statement of Rights under the Newborns' and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Specialized Infant Formulas

Specialized infant formula for children up to age 3 may be covered at 90%, provided they meet the following criteria:

- Formula must be medically necessary specialized oral or enteral dietary formulas required to treat disease or infant metabolic disorders.
- Documentation of medical necessity from an attending physician must be submitted along with the claim.

In general, a specialized infant formula is an oral or enteral dietary formula that is exempt from general requirements of nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration. It does not require legal prescription but must be intended for use solely under medical supervision in dietary management of specific diseases.

The Plan does not cover solid-food metabolic products.

Short-Term Rehabilitation - Restorative

Short-term rehabilitation is physical, occupational or speech therapy that is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function) which has been lost or impaired due to an injury or other specific incident such as an accident or illness.

Charges for short-term rehabilitation made by a physician or a licensed or certified physical, occupational or speech therapist for the treatment of acute conditions are covered under the Lehman Brothers Medical Plan, provided the treatment is:

- Furnished to a covered individual who is not confined as an in-patient in a hospital or other facility for medical care; and
- Expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

In-network restorative short-term rehabilitation is covered at 100% (after a $30 copay if a session is billed as an office visit). To be eligible for in-network benefits, you must be referred for short-term rehabilitation by a network physician to a network provider.

Out-of-network benefits for restorative short-term rehabilitation will be reimbursed at 70% of reasonable and customary charges, provided the therapy is deemed medically necessary and effective by Aetna. If Aetna determines that the therapy is not expected to result in significant improvement of your medical condition, reimbursement may be denied.

The Plan will cover up to 60 visits of rehabilitation therapy per calendar year, whether in- or out-of-network. The 60-visit limit applies to any combination of physical, speech and/or occupational therapy.

Restorative Speech Therapy

Speech therapy is a type of short-term rehabilitation. Included under Short-term Rehabilitation, are any charges for speech therapy performed by a physician or licensed, certified speech therapist that is designed to *restore* speech to a patient who has lost the ability to speak due to illness or injury.
See Short-term Rehabilitation for details.

Short-Term Rehabilitation – Developmental Delay

Developmental delay disorders are conditions that may result in the absence of or delays in speech development. Developmental delay disorders include but are not limited to autism, Rett syndrome, childhood disintegrative disorder and Asperger's syndrome.

Charges for Short-term Rehabilitation made by a physician or a licensed or certified therapist for the treatment of developmental delay conditions are covered under the Lehman Brothers Medical Plan, provided the treatment is not considered experimental or investigational. The plan administrator considers treatments experimental and investigational when the peer-reviewed medical literature does not support the use of these procedure and services in the assessment and treatment of developmental disorders.

In-network and out-of-network benefits for development delay short-term rehabilitation are covered at 70% of reasonable and customary for up to 30 visits as medically necessary.

Developmental Delays

Speech therapy is a type of short-term rehabilitation. The Plan will cover up to 30 visits of speech therapy performed by a physician, audiologist or speech pathologist on a patient with developmental delays such as autism or PDD. Costs will be reimbursed at 70% of reasonable and customary charges both in- and out-of-network.

Chiropractic Care

The Plan will cover up to 30 visits of chiropractic care per calendar year. The 30-visit limit applies to any combination of in- and out-of-network care.

In-network: If you utilize a chiropractor in the Aetna network, your coverage may vary depending on how your chiropractor bills for his or her services. If your provider bills your session as an office visit, the Plan covers 100% of cost after a $30 copay per visit. If your session is billed as a physical therapy session, the Plan covers 90% of the negotiated network cost and you are responsible for the remaining 10%.

Out-of-network: After you have met your calendar year deductible, the Plan will reimburse 70% of reasonable and customary charges.

Acupuncture

Covered Medical Expenses include those charges incurred for acupuncture services furnished to a covered family member only if provided by:

- A physician; or
- An acupuncturist certified by the American Association for Acupuncture and Oriental Medicine who is practicing within the laws of the jurisdiction where treatment is given.

Acupuncture services are those which are furnished:

- As a form of anesthesia in connection with surgery that is covered under this policy.
- To treat a non-occupational disease or non-occupational injury.
- To alleviate chronic pain.
- Adult postoperative and chemotherapy-induced nausea and vomiting.
- Nausea of pregnancy.
- Postoperative dental pain.
- Fibromyalgia and myofascial pain.
- Temporomandibular Disorders (TMD).

The Plan will cover up to 30 visits per calendar year.

In-Network

The Plan covers 100% after a $30 copay.

Out-of-Network

The Plan will reimburse 70% of reasonable and customary charges after you have met your calendar year deductible.

Durable Medical and Surgical Equipment

Durable medical and surgical equipment is defined as equipment that is prescribed by a physician and is:

- Made to withstand prolonged use;
- Made for, and mainly used in, the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Rental of durable medical and surgical equipment (except for the exclusions listed below) that has been prescribed by an in-network physician is covered at 100% of reasonable and customary costs. When prescribed by a non-network physician, rental costs are reimbursable as an out-of-network benefit, at 70% of reasonable and customary costs, after the annual deductible has been met.

The purchase of durable medical and surgical equipment and any accessories needed to operate the equipment is covered only if:

- Long-term use is planned; and
- The equipment cannot be rented, or Aetna determines that it is likely to cost less to buy it than to rent it.

Exclusions

The following durable medical and surgical equipment charges are not covered under the Plan:

- Charges for more than one item of durable medical and surgical equipment for the same or similar purpose.
- Eyeglasses.
- Orthopedic shoes or other devices to support the feet.

Hearing Aid Expenses

This Plan pays for charges for hearing aids for loss of hearing. Benefits will not be paid for more than the Hearing Aid Maximum of $400 per ear every three years.

Not covered are charges for:

- Evaluations and hearing aids rendered before the person becomes eligible for coverage or after termination of coverage.
- Hearing aid batteries.
- Hearing exams required as a condition of employment.
- Special education for a person whose ability to speak or hear is lost or impaired. This includes lessons in sign language, speaking aids and training in the use of such aids.

Infertility Program

Covered expenses for infertility treatment will be reimbursed at 90% for in-network services and at 70% for out-of-network services. In order to be covered, your infertility treatment plan must be submitted to Aetna for pre-approval (in- or out-of-network). Contact Aetna customer service at 800-345-4432 for information on how to submit a treatment plan.

There is a lifetime maximum of $15,000 for infertility benefits including prescription drugs under the Lehman Brothers Medical Plan.

Infertility is defined as 12 months of unprotected intercourse without conception. Coverage also applies for any condition for which the treatment of that condition would result in infertility.

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for infertility if:

- The procedures are performed while not confined in a hospital or any other facility as an inpatient.
- FSH levels are less than or equal to 19 miU on day 3 of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses will be Covered Medical Expenses:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of 6 courses of treatment in a covered person's lifetime.
- Cryopreservation of individual eggs
- Cryopreservation of sperm

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

Expenses Not Covered

The Plan will not cover charges for the following:

- Purchase of donor sperm;
- Care of donor egg retrievals or transfers;
- Cryopreservation of individual eggs;
- Storage of cryopreserved sperm, egg or embryo;
- Home ovulation predictor kits; and
- Gestational carrier programs.

Teeth, Mouth and Jaws (Including TMJ)

Dental care is *not* covered under the Lehman Brothers Medical Plan, except for the prompt repair of natural healthy teeth that are accidentally injured while you are covered by this Plan. (Benefits are not available for accidental injury of non-natural teeth and/or dentures.) See the Teeth, Mouth and Jaws section of Expenses Not Covered for further dental care exclusions.

Most services for Temporomandibular Joint Syndrome (TMJ) are not covered under the Lehman Brothers Medical Plan. See the Temporomandibular Joint Syndrome section of Expenses Not Covered for details about TMJ services not covered.

When medically necessary, however, and when appliance therapy alone cannot result in functional improvement, surgery to alter the jaw, jaw joints or bite relationships by a cutting procedure is a covered expense. You should submit a pretreatment review to Aetna before services begin to verify coverage of any benefits for the treatment of TMJ.

Mental Health and/or Substance Abuse

Under the Lehman Brothers Medical Plan, Mental Health and/or Substance Abuse services are covered under separate benefit provisions from other medical services.

In-Network

All in-network Mental Health and Substance Abuse benefits are managed by Aetna Behavioral Health, a division of Aetna specializing in the management of psychiatric care. You or your physician can obtain an in-network referral to a participating provider either for in-patient or out-patient services by calling Aetna Behavioral Health at 800-424-4047. In-network benefits are as follows:

In-patient: 90% of the negotiated network cost.

Out-patient: 100% coverage after a $30 copay per visit; limited to 50 visits per calendar year.

Out-of-Network

Out-of-network Mental Health and Substance Abuse benefits are as follows:

In-patient: Reimbursed at 70% of reasonable and customary charges, after you meet your deductible; all out-of-network hospitalizations must be precertified by Aetna Behavioral Health.

Out-patient: Treatment by a psychiatrist, psychologist or licensed medical social worker is reimbursed at 70% of reasonable and customary charges, after you meet your deductible. Benefit is limited to 50 visits per calendar year.

The copays and coinsurance for out-patient psychiatric care benefits are not applied towards your out-of-pocket maximums.

Mental Health counseling must be provided by a recognized counselor.

Aetna recognizes the following practitioners as legally qualified physicians for counseling when they are:

- rendering a service covered by the policy,
- licensed by the state or jurisdiction of practice; and
- practicing within the scope of their license.

- Licensed Professional Counselor LPC
- Medical Doctor M.D
- Osteopath D.O
- Psychologist Ph.D.,
- Social Worker M.S.W.

Telephonic counseling is available if the therapist has a pre-existing, face-to-face relationship with the patient prior to starting telephone therapy and there are extenuating circumstances that prevent face-to-face sessions.

Maximums (Combined In- and Out-of-Network)

The following Plan maximums refer to any combination of in- and out-of-network Mental Health and/or Substance Abuse services per covered individual:

In-patient: 30 days maximum per calendar year.

Out-patient: 50 visits maximum per calendar year.

Organ Transplants

Transplants that are non-experimental or non-investigational are a Covered Benefit. Coverage for a transplant where a Member is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

Aetna covers the following services when the member is the recipient of (or a potential recipient for) a covered organ or tissue transplant:

- Compatibility testing of prospective organ/tissue donors who are members of the immediate family (first-degree relatives, that is, parents, siblings and children) of a member selected for an organ transplant.
- Live organ/tissue donor fees.
- Cadaveric organ/tissue procurement preservation, storage and transportation fees as billed by the Organ Procurement Organization (OPO).
- Charges for activating the donor search process for donors in the registry, HLA-DR sample procurement and typing, donor physical examinations and laboratory tests, as well as bone marrow/stem cell procurement.

Note: Harvesting of tissue (stem cell) for storage purposes only is not eligible for coverage unless the affected Aetna member has a documented disease diagnosis that may require the use of that stored tissue. Requests for coverage of tissue storage for longer than 12 months are reviewed by Aetna's National Medical Excellence unit for medical necessity. If both the donor and the transplant recipient are covered by this plan, donor expenses are attributed to the transplant recipient's coverage. This plan does not extend coverage for donor services when the transplant recipient is not our member.

Organ Transplant National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an NME Patient's local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an NME Patient for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment. Also included are expenses incurred by a Companion for transportation when traveling to and from an NME Patient's home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an NME Patient for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment. The benefit payable for these expenses will not exceed the Lodging Expenses Maximum of $50 per person per night.

Also included are expenses incurred by a Companion for lodging away from home:

- while traveling with an NME Patient between the NME Patient's home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the Companion's presence is required to enable an NME Patient to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum of $50 per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a hospital or other temporary residence from which an NME Patient travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the NME Patient's home.

Travel and Lodging Benefit Maximum

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an NME Patient and ends on the earlier to occur of:
  - one year after the day the procedure is performed; or
  - the date the NME Patient ceases to receive any services from the facility in connection with the procedure.

Limitations

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one Companion who is traveling with the NME Patient.

Lodging Expenses do not include expenses incurred by more than one Companion per night.

Institutes of Excellence (IOE)

The Institutes of Excellence (IOE) transplant network is Aetna's national network for transplants and transplant-related services, including evaluation and follow-up care. Hospitals that have been selected to participate in our IOE transplant network have met enhanced quality thresholds for volumes and outcomes. Facilities have been contracted on a transplant-specific basis and are considered to be participating ONLY for the specific transplants for which they are contracted.

Only facilities designated for the IOE transplant network are considered participating for transplant-related services. Therefore, hospitals that participate in Aetna's network that are not designated as IOE facilities are considered *non-participating* for transplant-related services. Additionally, if a member utilizes an IOE for a transplant for which the facility is NOT specifically contracted, they are considered to be out-of-network and the out-of-network benefit level applies.

The initial criterion for a facility's inclusion in the IOE transplant network is:

- Enhanced organ-specific credentialing and quality standards;
- The National availability of and need for transplant facilities, on a transplant type specific basis.

An Institutes of Excellence transplant facility listing sorted by transplant type and by state is included on DocFind at, http://www.aetna.com/docfind/institutes_of_excellence.html.

Subrogation and Right of Recovery

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury**,** illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion

This plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

Prescription Drugs

Pharmacy Card

As a participant in the Lehman Brothers Medical Plan, you will receive a Prescription Benefit Card, separate from your Aetna ID card. Medco has established an extensive national network of preferred pharmacies that will accept the Prescription Benefit Card.

By using your Lehman Brothers Prescription Benefit Card at any of the Medco network pharmacies, your cost for a 30-day supply will be:

Type of Medication	Your Cost
Generic	10% of the total cost; maximum $100
Preferred brand	25% of the total cost; maximum $100
Non-preferred brand	50% of the total cost; maximum $100

If you have a prescription filled at a non-network pharmacy, or if you have a prescription filled at a network pharmacy without your Lehman Brothers Prescription Benefit Card, your reimbursement will be paid at the same level as if you purchased your prescription at a network pharmacy with your Lehman Brothers Prescription Benefit Card. You will be responsible for any payment above that amount.

For example: A generic drug is sold at an in-network pharmacy to Plan participants for the reduced amount of $40. Therefore, if you purchased this drug at an in-network pharmacy with your Lehman Brothers Prescription Benefit Card, you would be responsible for your $4 copay and the Plan will pay the remaining balance of $36. If you bought the same drug at a non-network pharmacy for $80, the plan would then reimburse you $36 and you would be responsible for the remaining balance of $44.

Copay Reduction/Waiver Programs

At times the Plan may decide to offer a special program to waive or reduce the copay for all participants in a certain situation (e.g. all participants taking a certain class of drugs, all participants filling prescriptions for a specific maintenance medication at retail pharmacies, all participants taking a brand name drug in a drug class with a newly available generic). These programs will be on a Plan basis and may be offered for whatever length of time the Plan Administrator deems appropriate.

Preferred Drugs

A preferred drug is any brand name prescription medication that Medco has evaluated for its therapeutic and economic value and has classified as “Preferred.” Brand prescription drugs that are not classified as preferred are “non-preferred.” In general, brand medications cost significantly more than generics. However, you will pay less for a preferred brand than you would for an equivalent non-preferred brand.

To find out whether your specific brand medication is preferred or non-preferred, refer to the Medco Preferred Prescriptions Drug list on their web site, www.medco.com (Note: you will need to establish a user name and password in order to access this site).

How Does the Card Work?

Use a Medco network pharmacy when filling prescriptions. Since the Medco network is nationwide, you can purchase your prescriptions even while traveling.

Present your card to your pharmacist at the same time you fill your prescriptions. Your pharmacist will ask for information about you and your covered dependents (if applicable).

Mail Order Prescription Drug Program

The Mail Order Prescription Drug Program, offered as part of the Lehman Brothers Medical Plan, is a convenient and economical way to purchase your long-term maintenance medications. You may order up to a 90-day supply (which may be filled up to four times within a 12-month period) from the mail order plan. Your cost per 90-day supply will be:

Type of Medication	Your Cost
Generic	10% of the total cost; maximum $250
Preferred brand	25% of the total cost; maximum $250
Non-preferred brand	50% of the total cost; maximum $250

How Does the Mail Service Program Work?

1. When your physician writes a prescription for a maintenance medication: if appropriate, ask him/her to write your prescription for up to a 90-day supply, with up to three (3) refills. For a new prescription, you may want to have your physician write two (2) prescriptions: one for a minimum of two (2) weeks' worth of medication that you can fill immediately at a retail pharmacy using your Prescription Benefit Card, and, and one for up to 90 days that you can fill using the Mail Service Program (delivery may take up to 2 weeks).
2. Complete the Medco Order Form for your first mail service order.
3. For new prescriptions, submit a new, original prescription with your order form.
4. Make your check payable to Medco, or furnish your credit card information in the section provided
5. Mail the completed form (and check, if applicable) to the address shown on the order form.

For rapid refills, visit www.medco.com or call 800-597-0179. Please allow 10-14 days from the date you mail your prescription order for delivery; overnight delivery service is available at an additional cost.

Internet Access to Your Prescriptions – www. medco.com

Medco has an integrated Internet site, www.medco.com. Through this site, you will be able to access your personal profile, including prescriptions filled at both the retail level as well as mail order for each covered family member. The information on Medco.com is confidential, and each family member can select an individual password.

Valuable information available on the Medco web site include:

- Information regarding prescription drugs, their uses as well as interactions;
- A disease reference guide;
- The ability to refill and track mail order prescriptions;
- A retail pharmacy locator; and
- The ability to purchase non-covered items (such as vitamins or health and beauty aids) through an alliance with DrugStore.com.

Prescription Drugs That Are Covered

Generally, drugs approved by the FDA that are prescribed by a physician are covered; this can include insulin and disposable syringes. Please note that some drugs may require prior authorization to determine eligibility for coverage and some drugs are only covered for specific quantities, for a specific period of time, or for the type of treatment which it was approved by the FDA (e.g., not for an off-label use).

Prescription Drugs That Are Not Covered

- Dietary supplements
- Immunization agents, biological sera, blood or blood plasma. (These items are covered as medical expenses under the Lehman Brothers Medical Plan only when they are dispensed during a certified hospital stay or physician's office visit.)
- Infertility medications, except in conjunction with the Infertility Program.
- Minoxidil (Rogaine®) for alopecia.
- Tretinoin (Retin-A®) in all dosage forms, for individuals 35 years of age or older.
- Anti-wrinkle agents such as Renova®, regardless of intended use.
- Drugs to treat impotency for individuals under 18 years old.
- Emergency contraceptives through mail order (only covered through retail pharmacies)
- Over-the-counter (non-prescription) medications.
- Therapeutic devices and appliances (except inhaler spacers).
- Blood Glucose Monitors.
- Topical dental floride treatments.
- Charges for administering or injecting a drug.
- Drugs labeled Caution limited by federal law to investigational use or experimental drugs. See the Experimental Services and Supplies section for exceptions.
- Drugs administered in hospitals, doctors' offices, clinics or similar institutions.
- Any prescription refilled in excess of the number specified by the physician or any refill dispensed more than one (1) year after the original date of prescription.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physician complications of the mastectomy, including lymphedema

Such coverage will be subject to annual deductibles and coinsurance provisions as deemed appropriate and are consistent with those established for other benefits under the Lehman Brothers Medical Plan.

Expenses Not Covered

The following pages contain a partial list of expenses not covered under the Lehman Brothers Medical Plan. Other exclusions are listed under "Covered Expenses" in the Durable Medical and Surgical Equipment section and the Prescription Drugs section. Copies of the Aetna Clinical Policy Bulletins, detailing specific exclusions, are available without charge from the HR Service Center.

Medical Necessity

Services or supplies that Aetna determines are not medically necessary are not covered under the Lehman Brothers Medical Plan regardless of who prescribes, recommends or performs these services.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional.
- Those excluded under an Aetna Clinical Policy Bulletin.
- Those furnished mainly for the personal comfort or convenience of the patient, any person who cares for the patient, any person who is part of the patient's family, any health care provider or health care facility.
- Those furnished solely because the person is an in-patient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined.
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Reasonable and Customary Limits

Out-of-network expenses in excess of the reasonable and customary limits defined in the Reasonable and Customary Charges section are not covered under the Lehman Brothers Medical Plan.

Experimental Services and Supplies

The Lehman Brothers Medical Plan does not cover any drug, device, procedure or treatment if:

- There are insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- If required by the U.S. Food and Drug Administration (FDA), approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

The experimental exclusion will not apply if one of the two following sets of criteria are met:

- All of the following criteria are satisfied:
  - The patient has a disease which is expected to cause death within one year in the absence of effective treatment; and

- The usual modalities of conventional, standard treatment have been unsuccessful; and
- The proposed treatment is promising and likely to be effective for the patient. A promising treatment is one where Aetna has determined that it has shown effectiveness as supported in credible peer reviewed literature or by the credible medical opinion of independent medical experts in the relevant specialty.

or

- The patient is to be treated as part of a clinical trial satisfying all of the following criteria:
  - The drug, device, therapy or procedure under investigation is under current review by the FDA and has been determined to be safe for human use; and
  - The clinical trial has been approved by an Institutional Review Board that will oversee the investigation; and
  - There is credible evidence in the peer-reviewed medical literature showing benefit from the proposed treatment; and
  - The clinical trial is sponsored by the National Cancer Institute or similar national cooperative body, and conforms to the rigorous independent oversight criteria as defined by that body for the performance of clinical trials.

Behavior Modification Therapy

The term “behavior modification therapy” refers to any course of therapy that attempts to modify observable, maladjusted patterns of behavior. Such therapy, including assertiveness training, aversion therapy, sensory integration therapy and adaptive behavioral analysis for children with autism or developmental disorders, is not covered under the Plan.

Custodial Care

“Custodial care” is defined as services and supplies furnished mainly to help a patient in the activities of daily living. This includes room and board and other institutional care. Custodial care is not covered regardless of who prescribes, recommends or performs these services.

Private Duty Nursing

Charges for private duty nursing are not covered unless Aetna precertifies them as a replacement for other, more expensive care.

End Stage Renal Disease

Individuals who have been diagnosed as having end stage renal disease are eligible for coverage under Medicare. Therefore, Medicare coverage is primary for all charges related to the treatment of end stage renal disease patients.

Temporomandibular Joint Syndrome

Most services for Temporomandibular Joint Syndrome (TMJ) are not covered under the Lehman Brothers Medical Plan. See the Teeth, Mouth and Jaws section for details.

Services and supplies primarily or exclusively used to permanently alter occlusion and/or reposition the lower jaw, including appliances or orthodontic banding and wiring, as well as myofunctional therapy, are considered dental in nature and are not covered under this Plan, whether or not the purpose of such service or supply is to relieve pain. See the Teeth, Mouth and Jaws section for further dental exclusions.

Teeth, Mouth and Jaws

Expenses for the treatment of the mouth, jaws and teeth are Covered Medical Expenses, but only those for services rendered and supplies needed for the treatment of or related to the conditions of the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves).

For these expenses, physician includes a dentist.

Hospital services and supplies received for an inpatient hospital confinement required because of the person's condition are covered including surgery need to:

- Treat a fracture, dislocation or wound;
- Cut-out cysts, tumors or other diseased tissues;
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Dental services that are appropriate, necessary, and required as the result of an accident are covered, including:

- Dentist's or oral surgeon's charges for repair of natural teeth or other tissues of the mouth;
- Cost of installing initial dentures, fixed bridgework, or crowns if they are necessary part of the repair work;
- Replacement of free-standing crowns or retainer abutments for fixed bridgework only when the injury requires re-preparation of the natural teeth.

The accident causing the injury must occur while the person is insured under the plan and treatment must be performed:

- During the calendar year of the accident, or
- The following calendar year.

In addition to the exclusions mentioned under the "Temporomandibular Joint Syndrome"section above, the following services and supplies are ***not covered*** expenses under the Lehman Brothers Medical Plan:

- Dental care, except for the repair of healthy, natural teeth damaged due to an injury suffered while covered under the Plan. (Benefits are not available for accidental injury of non-natural teeth and/or dentures.)
- The following dental work, except when provided for the repair of healthy, natural teeth damaged due to an injury suffered while covered under the Plan:
  - In-mouth appliances, crowns, bridgework, dentures, tooth restorations or any related fitting or adjustment services, whether or not the purpose of such service or supply is to relieve pain;

- Root canal therapy; and
- Tooth removal.

- Charges to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing.
- Charges to repair, replace or restore fillings, crowns, dentures or bridgework.
- Periodontal treatment.

How to Determine if an Out-of-Network Expenses is Covered

Before any major out-of-network treatment begins, you or your doctor should contact Aetna to determine whether the procedure is covered under the Plan and determine the reasonable and customary charge for such services. Contact Member Services at 800-345-4432 to obtain a "pretreatment estimate" form for any procedure.

Other Exclusions

- Services rendered by a health care provider who is not licensed to render such specific services.
- Services rendered by a health care provider who is not licensed to render such services in the state where the services were performed (e.g. licensed in NJ only, but performs the services in NY).
- Services provided and procedures performed before coverage begins or after it ends.
- Charges for failure to keep a scheduled appointment.
- Eyeglasses, or examinations for their prescription or fitting.
- Vitamins.
- Cosmetic surgery (unless reconstructive surgery is required following a mastectomy or as a result of an injury that occurs while you are covered under any Lehman Brothers Medical Plan option).
- Job-related accidents or illnesses covered by workers' compensation, or expenses which would have been covered by a state workers' compensation or private Workers' Compensation policy.
- Charges for services which are determined by Aetna to be educational in nature.
- Treatment for congenital disorders, birth defects and developmental delays.
- Emergency room services for non-emergencies. See the Emergency Care section for the definition of medical emergency.
- Emergency Medical Technician or Emergency Medical Service charges, except in conjunction with covered ambulance charges as described under Emergency Care.
- Exercise equipment, such as treadmills.
- Enteral Formula, unless ordered by a physician stating it is necessary for the patient whose condition would cause them to be malnourished or suffer disorders resulting in chronic disability, mental retardation or death.

How to Submit Your Medical Claims

The following procedures are applicable only to out-of-network claims. Out-of-network benefits are not available for prescription drugs. See the Prescription Drugs section for details on prescription drug coverage.

In-Hospital Charges

When admitted, present your Aetna ID card to the hospital admissions office. The hospital should bill Aetna directly. An out-of-network hospital may ask you to provide payment equal to your deductible (if not already met) and 30% of the anticipated charges, up to your out-of-pocket maximum, and any expenses that are not covered (such as private room charges). Aetna will make all payments directly to the hospital.

If you require emergency treatment and/or emergency admission at a non-network hospital, you are still entitled to in-network benefits. You or the hospital need to call the toll-free precertification number on your Aetna ID card for instructions on how to process non-network emergency claims. See the Emergency Care section under "Covered Expenses" for details.

Physician and Other Medical Charges

Please do not submit any claims to Aetna until you have bills which exceed your annual deductible.

Claims should be filed in the same calendar year in which you incur the expenses. Claims must be filed within two (2) years of the date of service or they will not be eligible for reimbursement.

Please use the proper claim form. Complete an Aetna Medical Benefits Request form ("claim form") for each claim you file. Aetna will not process claims submitted without a claim form. The address you list on the claim form is the address used for any reimbursement due you. You may obtain claim forms on Lehman & You, Frequently Requested Forms, under Claim Forms.

Always include your (the employee's) member ID number on your claim form. It serves as the identification number for you and your covered dependents. Without it, Aetna cannot process claims for you or any of your covered dependents.

Attach complete, itemized bills to your claim form. Itemized bills should include the following information: doctor's name and tax identification number, employee's name, employee's Social Security number, patient's name, date of service or purchase, condition being treated or diagnosis and the charge for each service or supply.

Send only original bills, not photocopies. Keep copies of all bills and claim forms for your own files.

Mail the claim form and itemized bills to the Lehman Brothers Claim Unit address that is listed on the form.

Retiree Medical Coverage

If you retire, you may be eligible to receive retiree medical coverage for yourself and your eligible dependents.

1. You are eligible to enroll in the Retiree Healthcare Program if you are an employee of Lehman Brothers Inc. and only if you meet all three of the following criteria:
    - You were hired by the Firm prior to December 1, 1999, and
    - At the time you leave employment you have been covered by one of the Firm-sponsored medical plans (excluding flexible spending accounts) for at least one year; and

- At the time you leave employment you satisfy what is known as the "rule of 75". That is your age plus number of years of service with the Firm equal at least 75, and you are a minimum of age 55, and you have a minimum of 10 years of service to be eligible.

If you worked for Lehman Brothers or one of Lehman Brothers' predecessor firms, terminated your employment with the Firm, and then rejoined the Firm at a later date, you have incurred a "Break in Service."

For purposes of the Retiree Healthcare Program, if your prior service with the Firm is greater than your time away, your prior service will be counted towards eligibility and the Rule of 75. For example, if you worked for the Firm for eight years, left for two years and were then rehired, your service calculation will include all of your service, even if you were rehired after December 1, 1999.

If your prior length of service with the Firm is less than your time away, your prior service will not be counted toward the rule of 75. For example, if you worked for the firm for two years, left the Firm for three years, and then were rehired, your service calculation will only include the service after your rehire date. If your rehire date was after December 1, 1999, you are not eligible for Retiree Healthcare coverage.

Your eligible dependents include your spouse/domestic partner and unmarried dependent children up to the age of 19 or 25 if they are a full-time student. In order to be eligible for coverage, your dependents must have been covered under a Lehman Brothers Medical Plan for one year or more prior to the time you retire. If you marry or remarry after retiring, you cannot add your new spouse or dependents to your Retiree Healthcare coverage.

2. You are eligible to enroll in the Retiree Medical Program if you are an employee of Lehman Brothers Inc. and only if you meet both of the following criteria:

   - At the time you leave employment you have been covered by one of the Firm-sponsored medical plans for at least one year; and
   - You met the Rule of 75 on or before December 31, 1991.

   If you worked for Lehman Brothers or one of Lehman Brothers' predecessor firms, terminated your employment with the Firm, and then rejoined the Firm at a later date, you have incurred a "Break in Service." For purposes of the Retiree Medical Program, if your prior service with the Firm is greater than your time away, your prior service will be counted towards eligibility and the Rule of 75. If your prior length of service with the Firm is less than your time away, your prior service will not be counted toward the rule of 75.

   Your eligible dependents include your spouse/domestic partner and unmarried dependent children up to the age of 19 or 25 if they are a full-time student. In order to be eligible for coverage, your dependents must have been covered under a Lehman Brothers Medical Plan for one year or more prior to the time you retire. If you marry or remarry after retiring, you cannot add your new spouse or dependents to your Retiree Medical Program coverage.

3. You are eligible to enroll in the Neuberger Berman Retiree Program if you are an employee of Neuberger Berman and only if you meet all the following criteria:

   - At the time you leave employment you satisfy what is known as the "Rule of 70." That is, your age plus number of years of service with the Firm equal at least 70, and you are a minimum age of 55 and you have a minimum of 10 years of service to be eligible, and
   - You met the Rule of 70 on or before October 31, 2003.

Coverage for retirees and spouses continues until age 65. Coverage for unmarried dependent children continues until they reach age 19 or 25 if they are a full-time student. In order to be eligible for coverage, your dependents must have been covered under a Lehman Brothers Inc. group medical plan for one year or more prior to the time you retire. If you marry or remarry after retiring, you cannot add your new spouse or dependents to your Neuberger Berman Retiree Medical Program coverage.

As with the plans covering active employees, Lehman Brothers reserves the right to change or discontinue any of these benefits and programs at any time without prior notice. This includes, but is not limited to, the level of benefits, eligibility for benefits and any cost to participants. The fact of your retirement does not provide you with any vested right to any retiree coverages.

Complete details regarding these plans can be found in their individual summary plan descriptions available by contacting the HR Service Center at 212-536-2363 or Hrservices@lehman.com.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges. Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

Companion. A person whose presence as a Companion or caregiver is necessary to enable an NME Patient:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility. An institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N.; and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N**.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay. A fee, charged to a person, which represents a portion of the applicable expense.

Custodial Care. Services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist. A legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

Durable Medical and Surgical Equipment. No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism or Drug Abuse. A program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and either:

- has a follow-up therapy program directed by a physician on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.
- Emergency Admission. When a physician admits the person to the hospital or treatment facility right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:
  - which requires confinement right away as a full-time inpatient; and
  - for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
    - placing the person's health in serious jeopardy; or
    - serious impairment to bodily function; or
    - serious dysfunction of a body part or organ; or
    - in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care. Treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition. A recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or

- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Home Health Care Agency. An agency that:
- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one physician and one R.N.; and
- has full-time supervision by a physician or a R.N.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan. A plan that provides for care and treatment of a disease or injury. The care and treatment must be:
- prescribed in writing by the attending physician; and
- an alternative to confinement in a hospital or convalescent facility.

Hospice Care. Care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency. An agency or organization which:
- Has Hospice Care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  - skilled nursing services; and
  - medical social services; and
  - psychological and dietary counseling.
- Provides or arranges for other services which will include:
  - services of a physician; and
  - physical and occupational therapy; and
  - part-time home health aide services which mainly consist of caring for terminally ill persons; and
  - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - one physician; and
  - one R.N.; and
  - one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program. A written plan of Hospice Care, which:

- Is established by and reviewed from time to time by:
  - a physician attending the person; and
  - appropriate personnel of a Hospice Care Agency.
- Is designed to provide:
  - palliative and supportive care to terminally ill persons; and
  - supportive care to their families.
- Includes:
  - an assessment of the person's medical and social needs; and
  - a description of the care to be given to meet those needs.

Hospice Facility. A facility, or distinct part of a facility, which:

- Mainly provides inpatient Hospice Care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians; at least one such physician must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a R.N.
- Has a full-time administrator.

Hospital. A facility that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of physicians.
- Provides 24 hour a day R.N. service.
- Is accredited as a hospital by either the joint Commission on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association.
- May be a general, acute care institution or a specialty institution provided that in either case, it is appropriately accredited as listed above and licensed by the proper state authorities.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N. A licensed practical nurse.

Mental Disorder. A disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

NME Patient. A person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary. A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge. The maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease. A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury. An accidental bodily injury that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-Preferred Care. A health care service or supply furnished by a health care provider that is not Preferred Care.

Non-Preferred Care Provider. A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Non-Preferred Pharmacy. A pharmacy that is not party to a contract with the Plan, or a pharmacy which is party to such a contract but does not dispense prescription drugs in accordance with its terms.

Non-Specialist. A physician who is not a specialist.

Non-urgent Admission. One which is not an emergency admission or an urgent admission.

Orthodontic Treatment. Any medical service or supply, or dental service or supply, furnished to prevent or to diagnose or to correct a misalignment:
- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain. Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Physician. A legally qualified physician, that is licensed in the state in which the services are provided.

Preferred Care. A health care service or supply furnished by:
- A person's Primary Care Physician or any other Preferred Care Provider.
- A Non-Preferred Care Provider on the referral of the person's Primary Care Physician and if approved by Aetna.
- Any health care provider for an emergency condition when travel to a Preferred Care Provider or referral by a person's Primary Care Physician prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care which is recommended and approved by the BHCC.

Preferred Care Provider. This is a health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with Aetna's consent, included in the Directory as a Preferred Care Provider for:
- the service or supply involved; and
- the class of employees of which you are member.

Psychiatric Physician. A physician who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N. A registered nurse.

Recognized Charge (also referred to as Reasonable & Customary)

Only that part of a charge made by a physician or dentist which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the Recognized Charge Percentage made for that service or supply.

In determining the recognized charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider; and
- the recognized charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

Semiprivate Rate. The charge for board and room which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area. The geographic area, as determined by Aetna in which Preferred Care Providers for this Plan are located.

Short Procedure Unit.

- Services involve use of an operating room for surgery that is completed and the patient is discharged on the same day.
- Distinguished from "outpatient department" which is for more minor procedures that generally require no or local anesthesia. (Examples of outpatient procedures perform in the outpatient department: endoscopy, colonoscopy, knee arthoscopy and chemotherapy administration)
- Generally involves general anesthesia.
- Is licensed as an ambulatory surgical facility by the jurisdiction it is in (states with licensing requirements),

- Is set up, equipped and run solely as a setting for surgery.

Specialist. A physician who:
- practices in any generally accepted medical or surgical sub-specialty; and
- is providing other than routine medical care.

A physician who:

- practices in such a sub-specialty; and
- is providing routine medical care (such as could be given by a primary care physician),

will not be considered a Specialist for purposes of applying this plan's **copay** provisions.

Terminally Ill. This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse). An institution that:
- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed with its effective treatment program.
  - Infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical services that may be required.
  - Supervision by a staff of physicians.
  - Skilled nursing care by licensed nurses who are directed by a full-time R.N.

Treatment Facility (Mental Disorder). An institution that:
- Mainly provides a program for the diagnosis, evaluation, and effective treatment of mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

Urgent Admission. One where the physician admits the person to the hospital due to:
- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

- A freestanding medical facility which:
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of physicians. At least one physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.
  - It is not the emergency room or outpatient department of a hospital.

or

- A physician's office, but only one that:
  - has contracted with Aetna to provide urgent care; and
  - is, with Aetna's consent, included in the Directory as a Preferred Urgent Care Provider.

Urgent Condition. This means a sudden illness, injury or condition; that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- does not require the level of care provided in the emergency room of a hospital; and
- requires immediate outpatient medical care that cannot be postponed until the covered person's physician becomes reasonably available.

Dental Plan

The Dental Plan is administered by MetLife. Under the Dental Plan you have two levels of benefits. You may use a network provider, (referred to as using the "in-network" benefit). Alternately, you may choose to see a provider not affiliated with the network (referred to as using the "out-of-network" benefit). You always have the choice to go in- or out-of-network while you are enrolled in the Plan.

This section of the Summary Plan Description contains a detailed description of the Dental Plan.

Eligibility and Enrollment - Dental Plan

If you are a U.S. benefits-eligible employee (see "Who Is Eligible for These Benefits"), coverage is available for you and your eligible dependents in the Dental Plan on the first day of employment provided you enroll within 31 days of hire.

An hourly employee whose status changes to U.S. benefits-eligible is eligible for coverage as of the date of the status change, provided you enroll within 31 days after the date the status change becomes effective.

Please note that you must be enrolled in the Dental Plan to enroll your dependent(s).

Late Enrollment/Open Enrollment

Enrollment in the Dental Plan is not automatic. Employees who do not enroll within 31 days of becoming eligible will not be eligible to enroll until the next annual Open Enrollment period (usually from mid-October through mid-November), with an effective date for coverage the following January 1.

Cost of Coverage

Pre-tax Monthly Employee Contributions

While the Firm pays most of the cost of coverage, you will be asked to pay a portion of the expense. Your monthly contribution, paid on a pre-tax basis, is determined by the type of coverage you choose. The following are the monthly pre-tax employee contributions for coverage under the Dental Plan:

Type of Coverage	Monthly Employee Contribution
Employee Only	$8
Employee Plus One Dependent Only	$16
Employee Plus Two or More Dependents	$24

The "employee plus one dependent" category is offered because an employees may want to cover only a spouse or a child. If you initially elect to cover yourself and one (1) dependent, you must designate the dependent that will be covered and you may not substitute a different dependent at a later point during the year. If you choose "family" coverage, there is no limit to the number of dependents that can be covered, but all dependent must be enrolled during the Open Enrollment period or within 31 days of your date of hire or a qualified family status change.

Calendar Year Deductibles (Out-of-Network Only)

Other than diagnostic and preventive services, all services that are provided by a dentist or specialist who is not in the MetLife network are subject to a calendar year deductible. The deductible is $50 per person. To help limit the number of deductibles you need to pay in any year, the Dental Plan has a family maximum deductible. Once any three (3) family members have each satisfied their $50 deductible, no further deductibles need to be met for covered family members.

Plan Benefits

In-Network Benefits

Network Providers

In order to receive the more generous in-network benefits, you must use dentists and dental specialists who participate in the MetLife network. When services are provided by a member of the MetLife network, you do not have to meet a deductible or file any claim forms. The dentist or specialist will file the claim for you and will collect your portion of the cost at the time services are rendered.

You can find network providers listed on MetLife's Web site, www.metlife.com/mybenefits . As a cost-saving measure, paper copies of the provider directories are not being provided. However, if you do not have access to the Internet you can call the Member Services line 800-942-0854 for a list of providers near you.

Diagnostic and Preventive Care

Under the Dental Plan, diagnostic and preventive dental care is covered at 100% when services are provided by a member of the MetLife network. Diagnostic and preventive care includes:

- Routine examinations - 2 per year
- X-rays: full x-rays every 60 months
- Bitewing x-rays: once per year for adults; twice per year for children
- Cleaning/scaling/polishing: 2 per calendar year
- Fluoride treatment (dependent children under age 19 only) – 1 per year
- Sealants on permanent molar teeth (to age 19 only) – one application every 60 months
- Emergency treatment of tooth pain

Restorative Services

Restorative services are reimbursed by the plan at 80%, when those services are provided by an in-network dentist or specialist. Restorative services include:

- Office visit consultations – 2 per year
- Fillings
- Extractions
- Root canal therapy – once per tooth in a 24 month period
- Periodontics and periodontal Treatment
- Oral surgery
- Relines and rebases to dentures – 1 per 36 months
- General anesthesia

- Space maintainers (to age 19 only)

Prosthodontic Services

Prosthodontic services are reimbursed by the plan at 60%, when those services are provided by an in-network dentist or specialist. Prosthodontic services include:

- Bridgework
- Dentures
- Crowns
- Inlays and onlays
- Implants

Orthodontics

Orthodontic services are reimbursed by the plan at 60% when those services are provided by an in-network orthodontist.

In-Network Maximums

For all in-network procedures, except orthodontics, you and each covered dependent can receive up to $2,500 in benefits each calendar year.

There is a separate lifetime maximum of $3,000 for in-network orthodontic care for each covered individual.

Out-of-Network Benefits

Reasonable and Customary Expenses

Out-of-network benefits are reimbursed at a percentage of "reasonable and customary" expenses. The reasonable and customary charge for a service or supply is the lower of:

- The provider's usual charge for furnishing it; or
- The charge MetLife determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable and customary charge for a service or supply that is unusual or not often provided in your area, or provided by only a small number of providers in your area, MetLife may take into account factors such as: complexity of the procedure, degree of skill needed, type of specialty of the provider, range of services or supplies provided by a facility and the prevailing charge in other areas.

Pretreatment Review

In order to determine how much the Plan will reimburse, your out-of-network dentist or specialist should submit a pretreatment request to MetLife prior to performing any services.

Diagnostic and Preventive Care

Under the Dental Plan, diagnostic and preventive dental care is covered at 80% when services are provided by a dentist or specialist who is not in the MetLife network. Diagnostic and preventive services are not subject to the annual deductible and include the following:

- Routine examinations - 2 per year
- X-rays: full x-rays every 60 months
- Bitewing x-rays: once per year for adults; twice per year for children
- Cleanings: 2 per calendar year
- Fluoride treatment (dependent children under age 19 only) – 1 per year
- Sealants on permanent molar teeth (to age 19 only) – one application every 60 months
- Emergency treatment of tooth pain

Restorative Services

Restorative services are reimbursed by the plan at 60%, when those services are provided by a dentist or specialist who is not in the Dental Plan network. Restorative services include:

- Office visit consultations – 2 per year
- Fillings
- Routine/surgical extractions
- Root canal therapy – once per tooth in a 24 month period
- Periodontics and periodontal Treatment
- Oral surgery
- Relines and rebases to dentures – 1 per 36 months
- General anesthesia
- Space maintainers (to age 19 only)

Prosthodontic Services

Prosthodontic services are reimbursed by the plan at 50%, when those services are provided by an in-network dentist or specialist. Prosthodontic services include:

- Bridgework
- Dentures
- Crowns
- Inlays and onlays
- Implants

Orthodontics

Orthodontic services are reimbursed by the plan at 50% when those services are provided by an orthodontist who is not in the Dental Plan network.

Out-of-Network Maximums

For all out-of-network procedures, except orthodontics, you and each covered dependent can receive up to $1,500 in benefits each calendar year.

There is a separate lifetime maximum of $2,000 for out-of-network orthodontic care for each covered individual.

Exclusions and Limitations

Reasonable and Customary Limits

Out-of-network expenses in excess of the reasonable and customary limits, as defined in "Plan Benefits", are not covered under the Dental Plan. The following example demonstrates how reasonable and customary limits are applied.

Example of Reasonable and Customary Limit

- Your out-of-network dentist charges $300 for a specific restorative procedure.
- MetLife determines that the reasonable and customary limit for that procedure is $200.
- The difference ($100) is not a covered expense under the Plan; it is not reimbursable and does not count toward your deductible.
- The reasonable and customary portion of the expense ($200) is a covered out-of-network expense, reimbursable at 60% ($120) after you have met any required deductible.

Replacement/Addition to Bridgework/Dentures

The replacement of or addition to existing dentures or bridgework is not covered under the Dental Plan. This exclusion will not apply if MetLife is furnished proof that:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. The patient must have been covered under a Lehman Brothers dental plan when the teeth were extracted.

The existing denture or bridgework is at least five (5) years old and cannot be made serviceable.

The denture being replaced is an "immediate" temporary one (not a replacement for a prior temporary) and cannot be made permanent. Replacement by a permanent denture is needed and takes place within 12 months of the initial installment of the immediate temporary one.

TMJ Treatment

Dental services for Temporomandibular Joint Syndrome (TMJ) are not covered under the Dental Plan.

Services and supplies primarily or exclusively used to permanently alter occlusion and/or reposition the lower jaw, including appliances or orthodontic banding and wiring and myofunctional therapy, are considered orthodontic in nature.

Experimental Services and Supplies

The Dental Plan does not cover any drug, device, procedure or treatment if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- If required by the FDA, approval has not been granted for marketing; or

- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Services Not Performed by a Dentist

Except for the three (3) procedures listed below, the Dental Plan will not provide coverage for any services not rendered by your attending dentist or physician. Services rendered in a hospital by either a resident physician or an intern are not covered under the plan.

The following three (3) procedures are covered expenses when performed by a licensed dental hygienist under the supervision of a dentist:

- Cleaning of teeth;
- Scaling of teeth; and
- Topical application of fluoride.

Cosmetic Services

Services and supplies that are, in whole or in part, cosmetic in nature are not covered under the Dental Plan. This includes teeth whitening and the personalization or characterization of dentures.

Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons, are not covered under the plan, except to the extent needed to repair an injury that occurs while you are covered under the Lehman Brothers dental plan. To be covered, the surgery must be performed by the end of the calendar year following the calendar year in which the accident occurred.

Other Exclusions

- Initial installation of a denture or fixed bridgework to replace congenitally missing teeth or to replace teeth lost while the patient was not covered under a Lehman Brothers dental plan. This includes inlays and crowns as abutments.
- Services provided and procedures performed before coverage begins or after it ends.
- Charges for failure to keep a scheduled appointment.
- Replacement of a lost, missing or stolen crown, bridge, denture or other dental appliance.
- Expenses that are covered by employer liability laws, workers' compensation or occupational disease laws, or under "no-fault" auto insurance law.
- Services paid for, or for which benefits are provided or required, by reasons of your past or present service in the armed forces of a government.
- Repair or replacement of an orthodontic appliance
- Services or supplies for which no charge would have been made in the absence of Dental Benefits
- Services or supplies for which a Covered Person is not required to pay
- Adjustment of a denture or a bridgework which is made within 6 months after installation by the same dentist who installed it
- Any duplicate appliance or prosthetic device
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride provided in a dental office

- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Temporary or provisional restorations or appliances
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before Dental Expense Benefits started or as a replacement for congenitally missing natural teeth
- Charges by the Dentist for completing dental forms
- Sterilization supplies or charges
- Services or supplies furnished by a family member
- Services or supplies received before dental expense benefits start for that person
- Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's employer
- Services or supplies to the extent that benefits are otherwise provided under the plan or under any other plan which the Employer contributes to or sponsors

How to Submit Your Dental Claims

The following procedures are applicable only to out-of-network claims under the Dental Plan. In-network claims will be filed for you by your dental care provider.

Even if you already submitted a pretreatment estimate form, you still need to submit a claim form for the work done, after it has been completed.

1. Please do not submit any claims to MetLife until you have bills which exceed your annual deductible.
2. Claims should be filed in the same calendar year in which you incur the expenses. Claims must be filed within two (2) years of the date of service or they will not be eligible for reimbursement.
3. Please use the proper claim form. Complete a MetLife Dental Benefits Request form ("claim form") for each claim that you file. MetLife will not process claims submitted without a Dental Benefits Request form. The address you list on the claim form is the address used for any reimbursement due you.
4. Always include your (the employee's) Social Security number. It serves as the identification number for you and your covered dependents. Without it, MetLife cannot process claims for you or any of your covered dependents.
5. Attach complete, itemized bills to your claim form. Itemized bills should include the following information:
    - Dentist's name and tax identification number;
    - Employee's name;
    - Employee's Social Security number;
    - Patient's name;
    - Date of service or purchase;
    - Condition being treated or diagnosis; and
    - The charge for each service or supply.
6. Send only original bills, not photocopies. Keep copies of all bills and claim forms for your own files.
7. Send all dental claims and itemized bills to: MetLife Dental, P.O. Box 981282, El Paso, TX 79998-1282.

Vision Care Plan

The Vision Care Plan (the "Plan") is designed to assist you with the purchase of routine vision products and services for you and/or your dependents. The Plan is administered by Davis Vision, which currently has over 10,000 providers nationally in its Vision Care network. When you use Davis Vision providers and materials, there is virtually no out-of-pocket cost to you (see "In-Network Benefits" for details).

There are very limited out-of-network benefits. If covered individuals do not use the Davis Vision providers, the Plan provides only a small, fixed reimbursement (see "Out-of-Network Benefits" for details).

Highlights of the Vision Care Plan

The following pages contain a detailed description of the Vision Care Plan. Below is a list of some of the highlights of the Plan's provisions:

- Comprehensive eye examination from a Davis Vision network provider every calendar year, with no copayment.
- Choose from any one of Davis Vision's 300 name-brand and designer frames every calendar year, with no copayment.
- Virtually any type of eyeglass lenses available every calendar year, most with no copayment.
- Generous discounts if you wish to purchase eyeglass frames or contact lenses that are not covered under the Plan, or if you purchase a second pair of eyeglasses.
- If you use the Davis Vision provider network, you do not need to file any claim forms.

Eligibility and Enrollment

If you are a U.S. benefits-eligible employee (see "Who is Eligible for These Benefits" coverage for you and/or your eligible dependents in the Vision Care Plan is available on the first day of employment provided you enroll within 31 days of hire.

Hourly employees whose status changes to U.S. benefits-eligible are eligible for coverage as of the date of their status change, provided they enroll within 31 days after the status change becomes effective.

Under the Vision Care Plan, you do not have to be enrolled to cover your dependent(s). For example, you may choose to waive coverage for yourself, but enroll your spouse in the Vision Care Plan. Your monthly employee contributions for participation in the Vision Care Plan are based on the number of individuals you wish to cover (see "Cost of Coverage").

Late Enrollment/Open Enrollment

Enrollment in the Vision Care Plan is not automatic. Employees and/or eligible dependents who do not enroll within 31 days of becoming eligible will not be eligible to enroll until the next annual Open Enrollment period (usually from mid-October through mid-November) with an effective date for coverage the following January 1.

Making Changes to Vision Coverage

Because your employee contributions are made on a pre-tax basis, the Internal Revenue Service requires that your election stay in effect throughout the full Plan Year. Once you make an election, you cannot change your election during the year unless you undergo what the IRS calls a "qualified family status change." The "Qualified Family Status Changes" table lists the events that qualify and which documentation is required.

Cost of Coverage

Your monthly premium, paid on a pre-tax basis, is determined by the number of individuals covered. You yourself do not have to be enrolled to cover a dependent or spouse. See the chart below for the monthly pre-tax employee contributions for coverage under the Vision Care Plan.

Vision Care Plan Monthly Employee contributions

Coverage Level	Monthly Pre-Tax Employee Contribution
One (1) Family Member	$8.33
Two (2) Family Members	15.02
Three (3) or More Family Members	22.51

You must designate the covered individuals and you may not substitute a different individual at a later point during the year. If you choose to cover "Three or More Family Members", there is no limit to the number of individuals that can be covered, but they all must be enrolled during the Open Enrollment period or within 31 days of your date of hire or a qualified family status change.

Plan Benefits/Covered Expenses

Davis Vision Providers

Network providers are listed in the Davis Vision provider directory. For a list of providers near you, access the Davis Vision Web site at www.davisvision.com to find a network provider near you.

There are two types of network providers:

"Tower" Provider: In addition to performing examinations and providing prescriptions, these providers have the Davis Vision Premier Collection of frames, which are covered under the Plan with no copayment. Davis Vision supplies a display rack to providers, which is often referred to as the "Davis Vision Tower." There are approximately 300 name-brand and designer frames on the Tower.

"Examination-Only" Provider: These providers can perform examinations and provide prescriptions. However, frames and lenses will have to be selected at another provider location.

In-Network Benefits

You are entitled to a comprehensive eye examination every calendar year. When the exam is performed by a Davis Vision participating provider, there is no copayment required.

Every 12 months you are entitled to new eyeglass frames. When you choose from the Davis Vision Premier Collection, there is no copayment required for the frames.

If you choose to purchase non-"Tower" frames from your Davis Vision provider, you can do so at a significant discount, calculated as follows: Wholesale cost of frames, minus $50, times 2 = your cost. *For example*: A brand-name frame that retails for $329 may have a wholesale cost of $90. Your cost would be calculated as ($90 - $50) x 2, for a total out-of-pocket cost to you of $80.

If you purchase a second pair of glasses from your Davis Vision provider, you are eligible for a 20% discount on any frames.

In addition, you are entitled to an annual (every 12 months) selection of eyeglass lenses or contact lenses as noted below:

Eyeglass Lenses

The following lens features are available with no copayment:

- Plastic or glass lenses, in any prescription range, including single vision, bifocal and trifocal lenses;
- Fashion, sun or gradient-tinted plastic lenses;
- Polycarbonate lenses;
- Blended invisible bifocal lenses;
- Glass grey #3 prescription lenses;
- Oversize lenses;
- Post-cataract (lenticular) lenses;
- Ultraviolet (UV) protective lens coating;
- SuperShield® (scratch-protective) lens coating; and
- Photogrey Extra® (sun-sensitive glass) lenses.

The following lens features are available with an additional copayment.

Special Feature	**Copay**
Polarized Lenses	$ 75
Anti-Reflective Coating • Standard • Premium (Crizal)	 35 48
Plastic Photosensitive Lenses (Transitions®), Single Vision or Multifocal	65
High Index Lenses	55
Progressive Addition Lenses (PALS)- • Standard types • Premium types (Kodak®, Varilux®,etc	 0 40
Intermediate Vision Lenses	30

Note: Davis Vision provides a one-year unconditional breakage warranty for all eyeglasses (frames and lenses) that are fully supplied by Davis Vision.

Contact Lenses

In lieu of eyeglass lenses, every calendar year, the Plan provides a $175 credit which can be used toward the purchase of contact lenses, fitting fees and follow-up care. You are responsible for any cost in excess of the $175 credit.

The $175 credit is applicable to any type of contact lenses in your provider's selection, including toric or gas permeable lenses.

A mail order replacement contact lens service, Lens 1-2-3®, is also available. For more information, including costs, please call Lens 1-2-3® at 800-536-7123.

Out-of-Network Benefits

There is limited coverage for services and supplies furnished by non-network providers.

If you use non-Davis Vision provider, you are eligible for out-of-network reimbursement based on the following schedule:

- Exam: up to $30.
- Lenses: Up to $25 for single vision correction, up to $35 for bifocal, up to $45 for trifocal, up to $60 for leticular.
- Eyeglass frames only: up to $50.
- Contact lenses: up to $100.

Expenses Not Covered Under the Vision Care Plan

The following services and supplies are not covered under the Vision Care Plan:

- Medical treatment of eye disease or injury. This is generally covered under most medical plans.
- Visual therapy.
- Special lens designs or coatings, other than those listed in the "In-Network Benefits" section.
- Replacement of lost eyewear.
- Non-prescription lenses.
- Two pairs of eyeglasses in lieu of one pair of bifocals.
- Eyeglasses and contact lenses during the same benefit period.

How to Submit Your Vision Care Claims

In-Network

No claim forms are required for in-network benefits. To access service, please:

1. Call the network doctor of your choice and schedule an appointment. For a copy of the network provider directory for your home or work state, please call Davis Vision at 800- 999-5431. You can also access provider directories on Davis Vision's Web site at www.davisvision.com.
2. Identify yourself as a Lehman Brothers employee or dependent.
3. Give the provider's office staff the employee's Social Security number and the year of birth of any covered dependent needing services.

4. The doctor's office will verify your eligibility in advance.

Out-of-Network

If you purchase eyeglass frames or contact lenses that are not covered under the Plan, or if you go to an out-of-network provider, please:

1. Pay the provider directly for all services and/or products.
2. Submit your paid claims with all itemized bills to: Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.

To obtain claim forms, please visit LehmanLive under the Lehman & You page, click on claim forms.

Flexible Spending Accounts

What is a Flexible Spending Account?

A Flexible Spending Account ("FSA") is an IRS-regulated tax-free account that can save you money on your health care and day care costs. You will not have to pay federal income and Social Security taxes on money you contribute to cover qualifying health care or day care expenses.

All Flexible Spending Account contributions are permanently exempt from federal income and Social Security taxes. In most states, you will not have to pay state taxes either.

How it Benefits You

A Flexible Spending Account may save you money and may be useful in many situations, for instance, if:

- You wear glasses or contacts;
- You regularly meet your medical and/or dental deductibles each year;
- You are planning extensive dental work;
- Your child is in day care; or
- An elderly dependent is receiving home care services.

How it Works

Flexible Spending Accounts are funded by your pre-tax payroll deductions. Your Flexible Spending Account reimburses you for qualified health care and/or day care bills you have paid during the year. There are differences in the way bills are reimbursed depending on which Flexible Spending Account you use, Health Care or Day Care. See the "How to File a Claim" sections for more details.

The "Use It or Lose It" Clause

Under Internal Revenue Service regulations governing Flexible Spending Accounts, you must:

1. Incur all eligible expenses by the Plan year during which your Flexible Spending Account contribution is in effect (generally, the Plan year is the period from the later of January 1st or your hire date through December 31st); and
2. Request reimbursement of those eligible expenses incurred by the deadline that is announced annually, usually in mid-June of the following calendar year.

For example, during the open enrollment period for 2008 an employee elects to contribute $1,000 to their Health Care Flexible Spending Account. Between January 1st 2008 and December 31st 2008 they will have $1,000 deducted from their paychecks. This $1,000 account balance can be used for qualified health care bills the employee incurs between January 1st 2008 and December 31st 2008; provided that the employees requests reimbursement for those expenses by the June 2009 deadline.

If you do not submit your expenses for reimbursement by the deadline, any balance remaining in your account will be forfeited. That is why it is important to plan your contributions carefully.

Forfeited funds are used to defray the administrative costs of the Plan.

Effect of Pre-Tax Contributions on Other Benefits

Contributions to your Flexible Spending Account will not impact your earnings for purposes of calculating pension benefits under the Retirement Plan; contributions under the Lehman Brothers Savings Plan; and earnings for Life and Disability coverage. However, because you are lowering your taxable income for Social Security purposes, your Social Security benefits may be reduced if you contribute large amounts of income to your Flexible Spending Accounts.

Eligibility and Enrollment

Enrollment in the Flexible Spending Accounts is available for U.S. benefits-eligible employees (see the "Who Is Eligible for These Benefits" section) who enroll within 31 days of hire, or during the annual Open Enrollment period. Hourly employees whose status changes to salaried part-time or full-time may enroll within 31 days after their status change takes effect.

There are additional eligibility requirements for the Day Care Spending Account. See the "Eligibility" section of the Day Care Spending Account section for details.

You designate the amount you wish deducted from your paycheck and contributed to each Spending Account. This is called your "election." The annual amount(s) you specify will be deducted in equal installments from each paycheck and deposited to either or both of the accounts, as you specify. Throughout the year, you can view statements of your account balances directly at www.WageWorks.com.

Late Enrollment/Open Enrollment

Enrollment is not automatic. Eligible employees who do not enroll in an FSA within 31 days of hire will not be eligible to enroll until the next annual Open Enrollment period, usually from mid-October through mid-November.

You may be eligible to enroll in the Day Care Spending Account mid-year, if you experience a qualified family status change. See the "Mid-Year Changes to Your Election" section for details.

How to Enroll

Through e-Benefits, you may enroll in the Flexible Spending Account(s) of your choice (Health Care, Day Care or both).

Health Care Account

Enter your annual payroll deduction through e-Benefits. If you are enrolling during the Open Enrollment period, your annual election will be divided by twelve (rounding up to the nearest whole dollar) and that amount will be your monthly payroll deduction. If you are enrolling as a new hire, the monthly payroll deduction will be calculated based on the number of payrolls remaining in the calendar year, and deductions will begin with your next paycheck.

Day Care Account

Important Note: The Internal Revenue Service sets an annual Day Care election limit of $5,000 per family. You are responsible for coordinating your annual election with your spouse and/or a prior

employer's Flexible Spending Account. See the "Maximum Contributions" section for further limitations on the Day Care Account.

If you are enrolling during the Open Enrollment period, your annual election will be divided by twelve (rounding up to the nearest whole dollar) and that amount will be your monthly payroll deduction. If you are enrolling as a new hire, the monthly payroll deduction will be calculated based on the number of payrolls remaining in the calendar year, and deductions will begin with your first paycheck.

Note: Remember, your Day Care provider must have a Social Security number or a tax ID number in order for expenses to be eligible for reimbursement.

Eligible Dependents

Health Care Account

You can use your Health Care Account to pay for health care expenses incurred by any of the following people - even if they are not covered by your employer's health plan:

- You
- Your spouse
- Your other dependents, as defined by the Internal Revenue Code

For purposes of your Health Care Account, a person will generally qualify as your dependent if he or she is either your child, brother or sister , grandchildren or niece or nephew and if he or she (i) lives with you for more than one-half of the year; (ii) is either under 19, a student under the age of 24 as of the end of the year, or totally and permanently disabled during the year; AND (iii) has not provided over one-half of his or her own support for the year. Additional close relatives may qualify if he or she lives with you for more than one-half of the year and you provide more than one-half of his or her support for the year.

Child of Divorced or Separated Parents. As long as the parents together provide over half the child's support, the child will be considered a dependent of both parents regardless of who can claim the tax exemption or is treated as the custodial parent.

Dependent Care

You can use your Dependent Care Account to pay for expenses to care for-certain dependents. Generally, to be eligible dependents they must live with you for more than one-half of the year and be one of the following:

- Your dependent who is under age 13 when the care is provided if the dependent is your child, brother or sister, niece, nephew, or grandchild and if he or she has not provided over one-half of his or her own support for the year.
- Your spouse who is physically or mentally incapable of caring for himself or herself.
- Your other close relative who is physically or mentally incapable of caring for himself or herself and who lives with you, provided that you provide more than one-half of his or her support for the year and he or she has earned less than the exemption amount (currently $3,100).

For more information please contact the HR Service Center at 212-526-2363.

Child of Divorced or Separated Parents. If you are the non-custodial parent, you cannot treat your child as an eligible dependent under the Day Care Spending Account even if you can claim the child as an exemption.

If you are the custodial parent, you may be able to treat your child as an eligible dependent even if you cannot claim the child as an exemption.

See IRS Publication 503 for details.

Mid-Year Changes to Your Election

If you experience certain qualified family status changes, you may be able to enroll, increase or decrease* your annual Spending Account election. You may not decrease your annual election below the amount you have contributed as of the date your change request has been received and processed. See the "Mid-Year Changes to Coverage" section for more details. The chart shown below details events that qualify as family status changes and whether you may enroll, increase or decrease your Spending Account annual election as a result.

Note: If you or your spouse stop working, you are no longer eligible to participate in the Day Care Spending Account under IRS guidelines. You should notify the HR Service Center to stop deductions.

Qualified Family Status Change

Qualifying Event	Permitted Change(s) to Day Care Spending Account
Marriage or domestic partnership	Enrollment Increase your election, or Decrease* your election
Divorce, legal separation or termination of domestic partnership	Enrollment Increase your election, or Decrease* your election
Birth or adoption of a child (including initiation of adoption proceedings); legal guardianship of a child	Enrollment Increase your election
Spouse or domestic partner becomes unemployed, loses coverage or takes unpaid leave of absence.	Increase your election
You take unpaid leave of absence	Decrease* your election
Death of spouse or dependent	Decrease* your election
Spouse or domestic partner becomes employed and/or becomes eligible for family coverage	Enrollment Increase your election, or Decrease* your election

When a decrease is allowable, you may decrease your annual election to an amount equal to the amount you have already contributed. This will have the effect of canceling future deductions. Due to IRS regulations, amounts already deducted from your pay cannot be refunded.

Becoming Ineligible for Flexible Spending Accounts

Generally, your eligibility to participate in the Flexible Spending Accounts ends when your employment terminates or you cease to be a U.S. benefits-eligible employee (see the "Who Is Eligible for These Benefits" section).

If your employment terminates during the year, you can continue to participate in your Health Care Flexible Spending Account for the remainder of the plan year through COBRA. See "Continuation Coverage" for details.

If you do not choose to continue to make a contribution on an after-tax basis after termination, the funds remaining in the account can only be used to reimburse you for services incurred prior to your termination date.

You cannot continue to participate in the Dependent Care Flexible Spending Account through COBRA, however, the funds remaining in your account can be used to reimburse you for services incurred through December 31 of the plan year.

Day Care Account Only: Your eligibility for the Day Care Account ends when your covered dependents no longer meet the definition of an eligible dependent, or you and your spouse cease to qualify under IRS guidelines.

If you cease to be eligible for reimbursement from the Day Care Spending Account, you must cancel your deduction through e-Benefits. See the "Mid-Year Changes to Coverage" section for details. Due to IRS regulations, deductions already taken cannot be refunded.

Pre-Tax Savings at-a-Glance

The following examples illustrate some potential savings available by utilizing a Flexible Spending Account. Your actual tax savings may vary based on your personal tax situation. These examples are estimated based on assumed federal income tax and FICA rates. If your contribution is also exempt from state and local taxes, savings may be even greater.

Example #1:

$50,000 Annual Taxable Income, Single Taxpayer, $1,200 in Eligible Expenses

	No FSA	With FSA
Gross Income	$50,000	$50,000
Minus FSA contributions ($42 per month)	-	(1,200)
W-2 Income	50,000	48,800
Minus Federal Income Tax*	(12,500)	(12,200)
Minus FICA	(3,825)	(3,733)
Minus After-Tax Health and/or Day Care Expenses	(1,200)	-
Income After Taxes and FSA Eligible Expenses	$32,475	$32,867
Federal Tax Savings Attributable to FSA contribution		$392

* Assumes a 25% tax rate.

This employee has saved $392 by contributing $1,200 to a Flexible Spending Account

Example #2:

$100,000 Annual Taxable Income, Married, Filing Jointly, $2,600 in Eligible Expenses

	No FSA	With FSA
Gross Income	$100,000	$100,000
Minus FSA contributions ($216.67 per month)	-	(2,600)
W-2 Income	100,000	97,400
Minus Federal Income Tax*	(28,000)	(27,272)
Minus FICA	(7,495)	(7,451)
Minus After-Tax Health and/or Day Care Expenses	(2,600)	-
Income After Taxes and FSA Eligible Expenses	$61,905	$62,677
Federal Tax Savings Attributable to FSA contribution		$772

*Assumes a 28% tax rate.

This employee has saved $772 by contributing $2,600 to a Flexible Spending Account.

Health Care Spending Account

Eligible Dependents

For the purposes of the Health Care Spending Account, a dependent is anyone who qualifies as a dependent under your health and/or dental plan, whether they are covered by a plan through Lehman Brothers or not.

Eligible Expenses

To be eligible for reimbursement for the Plan year, expenses must be for services rendered during the Plan year (January 1st, or date of hire if later, through December 31st) and must be paid for while a Health Care Spending Account election is in effect. New hires may not submit expenses that were incurred prior to their date of hire.

In some instances, health care providers will require a prepayment for services to be provided over a period of time (i.e., orthodontia and maternity care). The Health Care Spending Account can only reimburse you for services you actually receive within the Plan year and which are incurred while your election is in effect.

Eligible expenses include:

- Medical plan deductibles, copayments and coinsurance which are not covered under another medical plan or insurance. You must have receipts from your health care providers. *For example*: the 10% of costs you are required to pay as coinsurance under the terms of the medical plan or the copayment charged by the doctor for any office visit under the medical plan.
- Dental care: expenses not covered by any dental insurance or amounts in excess of any dental plan payment or annual maximum.

- Medical expenses to the extent not covered by any insurance plan, such as:
  - Acupuncture[3]
  - Prescription vitamin supplements, when prescribed for a medical condition;
  - A private hospital room
  - Vision testing, eyeglasses and contact lenses[4]

Some non-prescription medical equipment may be eligible for reimbursement with documentation of medical necessity. Contact WageWorks at 877-924-3967 to verify the expense before submitting a reimbursement request.

Expenses Not Covered

- Insurance premiums or payroll deductions paid by you, a spouse or a dependent. This includes COBRA payments.
- Expenses that are not considered deductible medical expenses by the IRS, such as cosmetic surgery.
- Expenses eligible for full reimbursement under any medical or dental plan (or a combination of plans) in which you or your dependents participate.
- Athletic club expenses, exercise equipment, hot tubs, whirlpool baths and swimming pools.
- Contact lens insurance.
- Non-prescription vitamins and natural foods.
- Your divorced spouse's medical bills or COBRA payments.

Election Maximum

You may fund a Health Care Spending Account for any amount from $120 to $5,000 per year ($10 to $417 per month) and use it to reimburse expenses incurred during the Plan year.

Restrictions

You may not claim a federal income tax deduction for any amount that has been reimbursed by a Flexible Spending Account. The IRS requires, as part of the Health Care Spending Account claim form, that you sign a document stating that the expenses submitted under the Health Care Spending Account are not eligible for reimbursement under any other plan.

How to Access Your Health Care Spending Account

Under the Health Care Spending Account, your total annual election is available for reimbursement on the first day of the plan year (or the first day of enrollment, if you are a new hire). You may request reimbursement for eligible expenses for any amount up to your total annual election, even if that amount has not yet been deducted from your pay.

[3] These expenses may be covered, or partially covered, by your medical plan.

[4] If you are enrolled in the Vision Care Plan, your copayments and any out-of-pocket vision care expenses are eligible for reimbursement from the Health Care Spending Account.

For example, you enrolled for an annual election of $1,200 ($100 per month) for plan year 2008. In February, you incur eligible expenses of $1,200 or more. You may request reimbursement of the entire amount in February, even though only $200 has been deducted from your pay. Payroll deductions will continue for the rest of the plan year.

There are 3 methods of accessing the funds in your account. You can use the WageWorks Health Care Card, have WageWorks mail a check directly to your provider through Pay My Provider, or you can submit a claim form through Pay Me Back.

The WageWorks Health Care Card

When you enroll in the Health Care Spending Account you will receive a WageWorks Health Care Card. The card works like a credit card that you can use to purchase eligible health care services and items at qualified merchants who accept MasterCard. The costs associated with all eligible transactions will be automatically deducted from your Health Care Spending Account. The card can be used to pay for co-payments, deductibles, prescriptions purchased at a pharmacy or through mail order, or prescription eyeglasses. Please be sure to keep your receipts and other records each time you use the card. In most cases WageWorks receives enough information about your purchase when you pay with the card to confirm that it was for an eligible expense. Occasionally WageWorks may require you to submit a receipt to verify the eligibility of an expense.

If you cannot show the card was used to pay for an eligible expense then you will be required to reimburse your Health Care Account for the amount of the purchase. If you do not reimburse your account, the amount due will be deducted from any future reimbursement checks.

If you misuse your card, such as charging ineligible expenses and not reimbursing your account upon request or regularly charging ineligible expenses, Lehman may suspend your card privileges for the current or future years and also may take additional disciplinary action. In addition to any disciplinary action taken, any unsubstantiated amounts that are not reimbursed will be considered taxable income to the employee, subject to withholding and inclusion on the your Form W-2.

Pay My Provider

You can instruct WageWorks to pay your provider directly through the Request Pay My Provider section under Health Care on WageWorks' website. WageWorks will write and mail a check directly from your account This payment option is convenient if you have regularly scheduled payments for eligible expenses such as physical therapy, or when you are billed for expenses not covered by insurance by your provider. The minimum Pay My Provider amount is $20.00.

Pay Me Back

You may submit a claim form to WageWorks and receive a reimbursement check in those cases where a provider does not accept credit cards, you are purchasing over-the-counter medications and need to submit a receipt or under other circumstances where you pay in advance. To receive a reimbursement check, complete a Pay Me Back Health Care Account Claim Form. Attach detailed, itemized bills to all claim forms.

You will have until mid-June of the following calendar year to submit claims for reimbursement of covered expenses incurred during the Plan year. No claims for covered expenses received after June of the following year will be accepted.

Forfeiture of Unused Amounts

Any funds not used during the calendar year for which they were designated will be forfeited in accordance with current IRS regulations.

How to Plan Your Health Care Spending Account Election

The online Health Care Spending Account Worksheet can help you estimate how much you might contribute to a Health Care Spending Account for the Plan year:

- Minimum annual contribution: $120 ($10 per month)
- Maximum annual contribution: $5,000 ($417 per month)

Estimate expenses you expect to incur between January 1st (or your date of hire, if later) and December 31st of the calendar year only. Expenses incurred before the calendar year or the year following the applicable calendar year will not be eligible for reimbursement from the Health Care Spending Account for that calendar year.

Day Care Spending Accounts

Eligibility

A Day Care Spending Account is for married working couples or single working people with eligible dependents (see the “Eligible Dependents” section). You may participate if you (or you and your spouse, if you are married) have dependents who require day care in order to allow you (or you and your spouse, if you are married) to work, or for your spouse to attend school.

If you do not currently have an eligible dependent, you may not enroll in the Day Care Spending Account at this time, even if you are planning to have or adopt a child during the calendar year. For example, if you are hired in February, and you expect to become a parent in June, you may not enroll in the Day Care Spending Account immediately. Once the child is born (or placed with you for adoption), you have 31 days in which you may enroll in the Day Care Spending Account for the remainder of the calendar year.

Maximum Contributions

You may fund a Day Care Spending Account for any amount from $120 to $5,000 per year ($10 to $417 per month) and use it for reimbursement for the expense of caring for your eligible dependents while you work. This account can be used to reimburse expenses for home child care, day care center costs, etc. (see the “Eligible Expenses” section), but not for the dependent’s medical expenses.

If you are married, the amount of expenses for which you can be reimbursed may not exceed the lesser of your earned income or your spouse’s earned income for the year. If your spouse is a full-time student, or is physically or mentally incapable of self-support, the IRS deems your spouse to have earned income of $200 per month. If this is the case, the maximum you may contribute to your Day Care Spending Account is $2,400 ($200 per month, $400 for 2 or more eligible dependents).

The IRS limits the amount of tax-free dollars each family can deposit in a Day Care Spending Account. If both you and your spouse elect to fund a Day Care Spending Account, your combined elections cannot exceed $5,000 ($417 per month). If you are married and filing separate tax returns, you and your spouse are each limited to a maximum election of $2,500.

If you are a new hire, and you participated in a Day Care Spending Account through your prior employer, you are responsible for coordinating your annual election between the two accounts.

Federal Tax Credit

For some people, the federal tax credit would result in a greater savings than using a Day Care Spending Account. It is best to consult your personal tax advisor if you are unsure which method would be best for you.

The federal tax credit is a percentage of eligible work-related expenses, such as the ones described in the "Eligible Expenses" section below. When calculating the federal tax credit on your income tax return, you must reduce your eligible work-related expenses, dollar-for-dollar, by any amounts excluded from income under the Day Care Spending Account. ***For example***, if you qualify for a federal tax credit based on $2,400 of eligible work-related expenses, and you funded a Day Care Spending Account of $1,000, your federal tax credit is based on eligible work-related expenses of $1,400.

Your Form W-2

Contributions to the Day Care Spending Account will appear in Box 10 on your Form W-2. While not included in taxable income, the amount shown in Box 10 will alert the IRS to your participation in this account.

Provider Identification

Any taxpayer claiming Day Care credit or excluding Day Care reimbursement from income must provide the name, address and taxpayer identification number or Social Security number of the dependent day care provider.

Eligible Expenses

To be eligible for reimbursement for the Plan year, expenses must be for services rendered and paid for:

1. Between January 1 and December 31 of the Plan year; and
2. While a Day Care Spending Account election is in effect. New hires may not submit expenses that were incurred before their date of hire.

In some instances, Day Care providers will require a prepayment for services to be provided over a period of time (e.g. 6 months in advance). The Day Care Spending Account can only reimburse you for services you actually receive within the Plan year and which are incurred while your election is in effect.

In addition, eligible Day Care services must have been incurred to enable you, if you are single, or you and your spouse, if you are married, to remain gainfully employed during a period in which there was at least one (1) eligible dependent residing in your household.

If you are married, you will be eligible for reimbursement of dependent day care expenses for your eligible dependent(s) only if your spouse is also employed, or if he or she is a full-time student.

Specific expenses eligible for reimbursement might include the following:

- Preschools, day care or elder care centers.
- Non-educational programs for children up to age 13 while schools are not in session (including summer day camp, but not including overnight camp).

- The cost for an individual to care for your children under age 13 inside or outside your home.
- Home care, non-medical nursing or nurse's aide services for a dependent parent who lives with you.
- Special non-medical care for mentally or physically handicapped dependents.
- FICA and FUTA taxes on wages paid to a dependent day care provider. If you use the services of a "Day Care center," the center must meet all requirements of state and local law. A "Day Care center" means any facility which provides care for more than six (6) individuals (other than individuals who reside there) and receives payment or grants for providing Day Care services.

Expenses Not Covered

You cannot be reimbursed for expenses incurred for the following:

- A dependent who is not an eligible dependent as defined in the "Eligible Dependents" section above.
- Baby-sitting during non-working hours (e.g., "Saturday night" baby-sitting).
- Payments to a dependent whom you or your spouse are entitled to claim as a dependent on your federal income tax return, such as an older child under age 19 who cares for a younger brother or sister.
- Food, clothing, education or transportation between your home and the Day Care facility.
- Nursing home meals and lodging.
- "Sleep-away" camp.
- Instructional services such as tennis or music lessons.

In addition, the Day Care Spending Account cannot reimburse expenses for out-of-home care of a dependent unless the dependent returns to the employee's home at night to sleep. You may not claim dependent day care expenses that exceed the lesser of:

- Your fixed dollar maximum under the Day Care Spending Account (see the "Maximum Contributions" section above);
- Your earned income; or
- You are married, your spouse's earned income.

How to Access Your Day Care Spending Account

You cannot be reimbursed for any amount unless that amount has already been deducted from your pay. For example, you enrolled for an annual election of $2,400 ($200 per month). In February, you incur reimbursable expenses in the amount of $2,400. The most you can be reimbursed in February is $400, the amount that has been deducted from your pay.

There are 2 methods of accessing the funds in your account. You can have WageWorks send a check directly to your provider through Pay My Provider, or you can submit a claim form through Pay Me Back.

Pay My Provider

You can instruct WageWorks to pay your provider directly through the Request Pay My Provider section under Dependent Care on the WageWorks Web site. WageWorks will write and mail a check directly from your account in the amount requested or your account balance before the payment date, whichever is lower.

Pay Me Back

You may submit a claim form to WageWorks and receive a reimbursement check. To receive a reimbursement check, complete a Pay Me Back Dependent Care Account Claim Form. Attach detailed, itemized bills to all claim forms.

The IRS requires, as part of the Day Care Spending Account Reimbursement Request form, that you sign a document stating that the expenses submitted under the Day Care Spending Account are not eligible for reimbursement under any other plan. The form also requires the caregiver's tax identification number (i.e., Social Security number or employer identification number).

How to Plan Your Day Care Spending Account Election

The online Day Care Spending Account Worksheet will help you estimate how much you might contribute to a Day Care Spending Account:

- Minimum annual contribution: $120 ($10 per month)
- Maximum annual contribution: $5,000 ($417 per month)

Estimate expenses you expect to incur between January 1 (or your date of hire, if later) and December 31 of the calendar year only. Expenses incurred before or after the calendar year will not be eligible for reimbursement from the Day Care Spending Account for that calendar year.

COBRA

Continuation Coverage

As part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and/or your eligible dependents who lose coverage under any of the Firm-sponsored health care plans (the Medical, Dental or Vision Care Plans and the Health Care Spending Account) as a result of the circumstances described in the chart below (called qualifying events) can continue coverage through the Firm at your (or your dependents') own expense. Of course, if you (or your dependents) are not covered under one or more of these plans, you (or they) are not eligible for continuation of coverage. If you (or your dependents) are eligible for Medicare benefits, you (or your dependents) are not eligible for continuation coverage under COBRA. You may, however, elect conversion (see the "Conversion Privilege" section for details).

Qualifying Event	Maximum Coverage Period
Reduced work hours	18 months
Resignation or employment termination (unless for gross misconduct)	18 months
Dependents of resigned or terminated employees	18 months
Employee's death	36 months
Divorce or legal separation	36 months
Dependent child whose eligibility ends (for example, exceeds Plan's age limit, is no longer a full-time student, gets married or becomes a full-time employee)	36 months
Employee or dependent who is disabled within 60 days of the qualifying event	29 months

Termination of Plan

Continuation coverage is not available if the Plan is terminated by the Firm.

COBRA Notification

Upon termination of your employment with Lehman Brothers, a COBRA notice and information package will automatically be sent to your home address on file.

Under COBRA, you (or your dependent) have the responsibility to inform the HR Service Center of a qualifying event, such as divorce, legal separation or a child's loss of dependent status within 60 days of the qualifying event. When the HR Service Center is notified, it will in turn notify you (or your dependent) of your (or your dependent's) right to choose continuation coverage.

You have 60 days from the date the COBRA notice is sent to you to select continuation coverage. If you choose continuation coverage, you will have 45 days from the date of your election to pay the first premium.

Payment for COBRA

COBRA requires you and your dependents to pay premiums promptly for continuation coverage. You will be notified by the Firm, or the claims administrator, of the amount of your premium (which includes the employee and employer costs, plus an administrative charge permitted by law).

For COBRA rates, contact the HR Service Center at 5-2363 (212-526-2363).

You (or your eligible dependents) have 60 days from the COBRA eligibility notice date to apply for continuation coverage, and your coverage will be retroactively reinstated to the date coverage terminated. Your first premium payment must be made within 45 days of the election of COBRA coverage. Thereafter, you will be billed monthly. Payment must be made within 31 days of the due date. If your payment is not received within 31 days of the due date, your COBRA coverage will be terminated retroactive to the first day of the month for which the premium has not been paid. Once terminated, your coverage cannot be reinstated.

Health Care Spending Accounts

If your employment terminates during the year, you are permitted to continue making contributions to your Health Care Spending Account on an after-tax basis for the remaining calendar year only.

If you do not choose to continue making contributions on an after-tax basis after termination, the funds remaining in the account can only be used to reimburse you for services incurred prior to your termination date

When Continuation Coverage Ends

Within the 18-month, 29-month, or 36-month continuation period, coverage for the applicable beneficiary will be terminated upon:

- Failure to make the necessary payments promptly.
- New coverage under another group health plan.
- Ceasing to be disabled (if COBRA coverage is being provided for a 29-month period based on disability).
- The Firm no longer provides group health coverage to any of its employees. (Coverage is subject to change at any time without prior notice or consent.)

If the new plan contains a pre-existing condition clause which affects the COBRA recipient, that person may continue COBRA coverage for the period of time designated by the pre-existing condition clause.

Conversion Privilege

At the time of termination of group coverage under the Aetna Choice POS II option of the Lehman Brothers Inc. Medical Plan, or upon expiration of the maximum term of continuation of coverage (18 months, 29 months, 36 months, or eligibility for Medicare), conversion to an individual basic medical policy (with very limited coverage) will be offered at the individual's expense. Individuals who terminate their Aetna Choice POS II COBRA coverage prior to the end of the 18-month, 29-month or 36-month continuation period will not be offered an individual policy.

Group Term Life Insurance

The following section discusses the Basic and Supplemental Term Life Program which is available to all new hires and to employees who earn less than $200,000 per year. For those employees who earn $200,000 per year or more, please see the "Group Variable Universal Life" section.

The ***Group Term Life Insurance Plan*** ("the Plan") is a fully-insured life insurance plan insured by MetLife. Coverage for eligible participants is based on Insurance Earnings (see the "Definition of Insurance Earnings" section), as follows:

- ***Basic Term Life Insurance***: An automatic, Firm-paid benefit providing term life coverage in the amount of one (1) times Insurance Earnings to a maximum of $100,000 of coverage.
- ***Accidental Death and Dismemberment Insurance***: An automatic, Firm-paid benefit providing accidental coverage in the amount of one-half of Basic Life Insurance to a maximum of $50,000 of coverage.
- ***Supplemental Term Life Insurance***: An elective, employee-paid benefit providing term life coverage of one (1) to nine (9) times Insurance Earnings to a maximum of $1,900,000 of coverage. To elect coverage greater than $1,500,000 you must provide a "proof of good health" statement for and be approved for the additional coverage.

The total maximum amount of term life insurance coverage under the Plan (Basic plus Supplemental) is $2,000,000.

Supplemental Term Life Insurance – Family Coverage: A voluntary, employee-paid benefit providing 100% of the Employees Supplemental Term Life Amount up to $100,000 of term life coverage for an employee's spouse/domestic partner and $10,000 of term life coverage for each eligible child. To elect coverage greater than $50,000 for your spouse/domestic partner, you must provide a "proof of good health" statement for your spouse/domestic partner and be approved for the additional coverage.

Eligibility and Enrollment

Coverage under the Plan is available on the first day of employment for U.S. benefits-eligible employees (see the "Who Is Eligible for These Benefits" section). Coverage for hourly employees whose status changes to U.S. benefits-eligible is available on the date their status change takes effect.

Each April 1, Insurance Earnings are recalculated and employees whose Insurance Earnings increase to $200,000 or more will automatically be transferred to Group Variable Universal Life, provided they satisfy all of the GVUL eligibility provisions. (See the "Group Variable Universal Life" section for details).

Enrollment in Basic Term Life and Accidental Death and Dismemberment is automatic.

Eligible employees who want Supplemental Term Life coverage must enroll ***within 31 days of their date of hire.*** Hourly employees whose status changes to U.S. benefits-eligible must enroll ***within 31 days of their status change.***

Late Enrollment and Changes to Group Term Life Insurance Coverage

Employees who do not enroll for Supplemental Term Life Insurance within 31 days of becoming eligible (or who wish to increase coverage at a later date) will be required to furnish proof of good health before being permitted to enroll (or increase coverage) at a later date.

There is no scheduled open enrollment for Supplemental Term Life Insurance, but you can provide evidence of good health to increase your coverage at any time.

Cancellation or Reduction in Coverage

You may cancel or reduce your Supplemental Term Life Insurance coverage at any time by e-mailing or faxing a memo to the HR Service Center, Hrservices@lehman.com; Fax Number: 646-758-5200. Include your name and Social Security number in the memo.

Changes Without Proof of Good Health

Within 31 days of a change in your marital status (including legal separation) or the birth or adoption of a child you do not need proof of good health to change your coverage level, subject to the following restrictions:

- If you have previously enrolled in the Supplemental Term Life Program, you are allowed to increase your coverage by 1 times your Insurance Earnings, up to the plan maximum of 9x Insurance Earnings or $1.9 million. Increase requests for more than 1 times Insurance Earnings require a proof of good health statement for the additional increase.
- If you are not currently enrolled in the Supplemental Term Life Program, you can enroll in the plan for up to 3 times your Insurance Earnings, up to a maximum of $1.5 million. Enrollments in excess of these limits require a proof of good health statement for the additional increase.

To request a change, please send an e-mail to the HR Service Center and HRServices@lehman.com or a fax to 646-758-5200. The e-mail or fax should contain your social security number, the date if the event and the type of change you wish to make. An event will be opened and you will be able to make the necessary changes online though e-Benefits.

Use of Insurance Earnings for Life Insurance

Coverage amounts for Basic Term Life and Accidental Death and Dismemberment are based on your Insurance Earnings, rounded to the next higher $1,000, and they change automatically with the annual recalculation of Insurance Earnings on April 1.

Coverage amounts for Supplemental Term Life Insurance are also based on your Insurance Earnings, rounded up to the next $1,000. You may elect coverage from one- to nine-times Insurance Earnings. Your Supplemental Term Life Insurance coverage will change automatically each April 1 with the annual recalculation of Insurance Earnings.

If your Supplemental Term Life Insurance coverage amount increases because your Insurance Earnings have increased, you will not be required to submit proof of good health to the insurance company. Your increased coverage will be automatically adjusted after the April recalculation.

Reduction at Age 65 and Over

While you are an active employee, on the April 1 following your 65th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 35%. On the April 1 following your 70th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 60%. On the April 1 following your 75th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 75%. On the April 1 following your 80th birthday, your Basic Term Life and Accidental Death and Dismemberment coverages will be reduced by 80%. The reductions are made each year based on your re-calculated Insurance Earnings. You may convert the reduced portion of your insurance amount to an individual policy by contacting the HR Service Center within 31 days of the reduction. See the "Converting to an Individual Policy" section for details.

Cost of Coverage

Basic Life and Accidental Death and Dismemberment coverage are provided at no cost to the employee. However, if your Insurance Earnings are in excess of $50,000, you may be taxed on the value of that excess. See the "Imputed Income" section below for details.

Premiums for Supplemental Term Life Insurance are calculated based on your age. Your premiums are recalculated each year, when Insurance Earnings are recalculated. The table below illustrates the age-based premiums in effect for 2008. These premiums have been set by MetLife and are not subsidized by the Firm.

Monthly Supplemental Premium Rates (Per $1,000 of Coverage)

Employee Coverage	
Your Age on April 1	Monthly Rate
Under 30	$.043
30-34	.060
35-39	.069
40-44	.086
45-49	.120
50-54	.206
55-59	.335
60-64	.566
65-69	.987
70 and Over	1.707

Family Coverage	
Your Age on April 1	Monthly Rate
Under 30	$.065
30-34	.087
35-39	.098
40-44	.120
45-49	.164
50-54	.274
55-59	.439
60-64	.736
65-69	1.275
70 and Over	2.199

Employee contributions for Supplemental Life Insurance are made on an after-tax basis and appear on your pay stub under "After-Tax Deductions."

Imputed Income

Federal tax law permits employers to provide you with up to $50,000 of firm-paid group term life insurance without creating additional taxable income. If you have over $50,000 in Basic Life Insurance, you will have additional taxable income recognized under federal tax laws. This income appears on your pay stub under "Taxable Benefits."

Naming a Beneficiary

All eligible employees should designate a primary and contingent beneficiary for the Group Life Insurance Plans. A beneficiary is the person designated by you to receive, in the event of your death, the proceeds or benefits from the life insurance plans in which you are participating at the time of your death. In the event that your primary beneficiary pre-deceases you, your contingent beneficiary will receive the proceeds from your life insurance plans. If you do not designate a beneficiary, or if your beneficiary(ies) pre-decease you, the proceeds would be paid in the following order:

1. Your spouse, if alive;
2. Your child(ren), if there is no surviving spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

For all or part of your life insurance for your dependents, the proceeds would be paid in the following order:

1. You, if alive;
2. Your spouse, if you are not alive;
3. Your child(ren), if there is no surviving spouse;
4. Your parent(s), if there is no surviving child;
5. Your sibling(s), if there is no surviving parent; or
6. Your estate, if there is no surviving sibling

Beneficiary changes to Basic Life, Supplemental Life, Basic Accidental Death & Dismemberment and Personal Accident Insurance can be made at any time through the e-Benefits site or through the HR Service Center.

You should routinely review your beneficiary designation to ensure it reflects your current wishes.

Plan Benefits

Death Benefits

In the event of the death of a covered employee, the Group Term Life Insurance Plan will pay the total amount of coverage under Basic Life and Supplemental Life to the beneficiary(ies) named by the employee in their most recent beneficiary designation.

In addition, if, as a result of a bodily injury suffered in an accident, a covered employee dies within one year of the accident, the Group Term Life Insurance Plan will pay the total amount of Accidental Death and Dismemberment coverage to the beneficiary(ies) named by the employee on the most recent Designation of Beneficiary record on file.

Accidental Injury Benefits

If a covered employee suffers a bodily injury in an accident and if, within one year of the accident, the employee suffers a Covered Loss, the Group Term Life Insurance Plan will pay a benefit to the employee.

The following Covered Losses will result in a benefit to the employee of 100% of the total Accidental Death and Dismemberment coverage:

- Loss of life; or
- Brain Damage (as defined in the certificate of insurance).

The following Covered Losses will result in a benefit to the employee of 75% of the total Accidental Death and Dismemberment coverage:

- Loss of an arm permanently severed at or above the elbow; or
- Loss of an leg permanently severed at or above the knee.

The following Covered Losses will result in a benefit to the employee of 50% of the total Accidental Death and Dismemberment coverage:

- Loss of a hand, at or above the wrist but below the elbow;
- Loss of a foot, at or above the ankle but below the knee;
- Loss of sight in one eye;
- Loss of speech;
- Loss of hearing;
- Paralysis of both legs; or
- Paralysis of the arm and leg on either side of the body.

The following Covered Losses will result in a benefit to the employee of 25% of the total Accidental Death and Dismemberment coverage:

- Loss of the thumb and index finger of the same hand; or
- Paralysis of one arm or leg.

The Plan will pay a Coma benefit of 1% of the total Accidental Death and Dismemberment coverage for each month, beginning after the 7th day of the coma, for the duration of the coma to a maximum of 60 months.

The Plan will pay the a benefit for each Covered Loss resulting from the same accident. However, no more than the full amount of Accidental Death and Dismemberment coverage is payable for all losses which result from one accident.

Limitations on Benefits

The life insurance coverage for a resident of the state of Texas may not exceed the greater of $250,000 or 7 times the individual's compensation. The maximum is combined for all MetLife insured group coverage's.

Under Family Coverage, the term life coverage for a child is only available for dependent children who are at least 15 days old.

Accidental Death and Dismemberment benefits are paid for losses caused by accidents only. No Accidental Death and Dismemberment benefits are payable for a death or loss caused or contributed to by any of the following:

- Bodily or mental infirmity
- Disease, ptomaines or bacterial infections, unless the infection results directly from an accidental injury
- Medical or surgical treatment, unless the surgery is needed because of an accidental injury
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- War or any act of war (declared or undeclared)
- Any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - parachuting or other descent from an aircraft, except for self-preservation;
- Travel in an aircraft or device used:
  - for testing or experimental purposes;
  - by or for any military authority; or
  - for travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician, or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes;
- Intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the accident

How to File a Claim

To report the death or accidental injury of a covered employee, contact the HR Service Center at 5-2363 (212-526-2363). A Benefits Representative will contact the employee's beneficiary(ies) directly in writing, requesting a copy of the death certificate and required tax information. In the case of a death or injury resulting from an accident, the Benefits Representative will request copies of accident/police reports as well as copies of any newspaper articles reporting the accident.

Death benefit information is confidential. No coverage or beneficiary information can be released without the beneficiary's consent. In the case of multiple beneficiaries, the HR Service Center will contact each beneficiary separately.

Converting Life Insurance to an Individual Policy

If any of your Basic and/or Supplemental Term Life Insurance coverage ceases because:

- Your employment terminates;
- You are no longer a U.S. benefits-eligible employee; or
- Because of age (as explained in the "Reduction at Age 65 and Over" section);

the amount of insurance which ceases may be converted to a personal life insurance policy. A lesser amount may be converted if you wish. No evidence of good health will be required.

If you wish to convert all or part of your Basic and/or Supplemental Term Life Insurance coverages to an individual policy with MetLife, contact the HR Service Center at 5-2363 (212-526-2363) and request a conversion application. You may request the application prior to your termination date.

The HR Service Center will complete the employer portion of the application and forward it to your home. Premium information will be indicated on the application. The premiums for the personal policy will be at MetLife's usual rates for the same policy issued to any other person of the same class of risk and age when the personal policy is to become effective. These premiums are higher than premium payroll deductions for active employees. After you have completed the application, forward it with your premium payment to the nearest address listed on the back of the application. MetLife must receive your application and premium payment within 31 days of the date your coverage ceases, or they will not issue an individual policy.

The converted policy will be a personal policy that is customarily being issued by MetLife for the amount being converted and for your age (nearest birthday) on the date it will be issued. It will not have disability or other benefits. The converted policy will take effect at the end of the 31-day period during which conversion is possible.

Group Variable Universal Life

What is Group Variable Universal Life (GVUL)?

All newly hired employees are eligible for the Group Term Life Insurance program on their first day of hire (see the "Eligibility and Enrollment" section).

Each April 1 the Firm recalculates Insurance Earnings. If your new Insurance Earnings are $200,000 or more, your Supplemental Term Life Insurance and $50,000 of your Basic Term Life Insurance will automatically be transferred to Group Variable Universal Life ("GVUL") insurance with Massachusetts Mutual ("MassMutual"), provided you satisfy the other GVUL eligibility requirements. Not included in the transfer is the first $50,000 of Basic Life insurance, which remains insured through MetLife.

In addition to the minimum Insurance Earnings, eligibility in the GVUL program is subject to certain eligibility requirements as outlined in the individual GVUL policies. These eligibility requirements include:

- You must be actively at work from January 1 to April1 in the year the insurances transfer to the GVUL program.
- If you are not based in the U.S., you may not be eligible for the GVUL program or your coverage may be limited.

If your Insurance Earnings are $200,000 or more, but you do not satisfy the GVUL eligibility requirements, you will remain in the Group Term Life Insurance Plan. Your Basic and Supplemental Term Life Insurance will transfer to the GVUL program on the first April 1 that you satisfy all of the GVUL eligibility requirements.

Eligible employees may elect GVUL coverage of one (1) times to five (5) times Insurance Earnings to a maximum of $2.9 million. If you enroll within 31 days of first being eligible, your coverage is not subject to medical underwriting. If you enroll at a later date you will be required to show proof of good health.

For Example: Your 2007 Insurance Earnings are $150,000 and you have elected Supplemental Life Insurance of two times earnings. Your coverage from April 1, 2007 through March 31, 2008 is as follows:

	Basic Life	Supplemental Life
Coverage Amount & Insurance Carrier	$100,000 MetLife	$300,000 MetLife
Type of Coverage	Term Life	Term Life

If, on April 1, 2008, your Insurance Earnings are re-calculated to be $200,000, your new coverage will be as follows:

	Basic Life	Supplemental Life
Coverage Amount & Insurance Carrier	$50,000 MetLife $50,000 MassMutual	$400,000 MassMutual
Type of Coverage	$50,000 Term Life $50,000 GVUL	GVUL

At the time your insurance coverage is converted, you will receive a package of information including application forms or directions on how to apply online. Due to the fact that GVUL coverages are individually owned policies, applications must be completed and signed by you, even for the coverage that is being provided by the Firm at no cost to you. Failure to complete the application process will result in a loss of your total GVUL coverage, including the portion of the coverage that is 100% Firm paid.

Personal Accident Insurance

The Personal Accident Insurance Plan ("the Plan") is a fully insured accidental death and dismemberment plan underwritten by the Life Insurance Company of North America. The Plan provides accident coverage for yourself in addition to the Accidental Death and Dismemberment coverage provided by the Firm under the Group Term Life Insurance Plan. You may also elect family coverage under the Plan, as described below.

Eligibility and Enrollment

Coverage under the Plan is available on the first day of employment for U.S. benefits-eligible employees (see the "Who Is Eligible for These Benefits" section). Coverage for hourly employees whose status changes to U.S. benefits-eligible is available on the date your status changes.

You may enroll in the Plan or make changes to your enrollment at any time.

Coverage

You may elect coverage for yourself in multiples of $10,000 up to a maximum of $1,000,000. The amount of coverage you elect is known as the "principal sum" under the Plan. The principal sum is payable if you die as a result of an accidental injury that occurred while covered under this Plan. Partial payment may be made for accidental dismemberment.

Family Coverage

If you elect family coverage, you are covered for the amount you select: the "principal sum" described above. In addition, your spouse or domestic partner and/or dependent children are also covered. The amount of insurance applicable to members of your family is based on the composition of the family at the time of loss, and is expressed as a percentage of your principal sum. The following table shows the different coverage levels (all percentages are based off of the principal sum):

	Coverage Level		
Family Composition	Employee	Spouse/Domestic Partner	Child*
Employee with a spouse/domestic partner and dependent children	100%	50%	15%
Employee with a spouse/domestic partner but no dependent children	100%	60%	N/A
Employee with dependent children but no spouse/domestic partner	100%	N/A	20%

Coverage level for a child is subject to a $100,000 maximum.

Examples of Family Coverage Benefit Calculations

1. An employee who had a spouse and dependent children looses their spouse in a covered accident. At the time of loss the employee's elected principal sum was $100,000.

Principal Sum	$100,000
Spouse coverage level	50%
Benefit Payable	$50,000

2. An employee who had a domestic partner but no dependent children passes away in a covered accident. At the time of loss the employee's elected principal sum was $250,000.

Principal Sum	$250,000
Employee coverage level	100%
Benefit Payable	$250,000

3. An employee with a dependent child but no spouse or domestic partner looses their child in a covered accident. At the time of loss the employee's elected principal sum was $500,000.

Principal Sum	$500,000
Employee coverage level	20%
Benefit Payable	$100,000

Under family coverage, dependents include your spouse or domestic partner, up to 70 years of age, and unmarried, dependent children up to 19 years of age, or up to age 25 if the child is a full-time student at an accredited institution of higher learning. Coverage will be extended beyond age 19 for an unmarried dependent child who:

- Is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation or physical handicap; and
- Became disabled before age 19 (age 25 if a full-time student); and
- Is chiefly dependent upon you for support and maintenance.

Proof of the dependent's incapacity must be submitted 31 days prior to attainment of the age at which the coverage would otherwise have ended.

Cost of Coverage

When you enroll in the Plan, you elect a coverage amount for yourself: the "principal sum" as described in the "Coverage" section. The monthly cost for employee-only coverage is $0.10 per $10,000 of principal sum. Family coverage costs $0.18 per $10,000 of your principal sum. Deductions appear on your pay stub under "After-Tax Deductions."

Examples of Monthly Premiums for Personal Accident Insurance

Principal Sum	Employee Only	Family Plan
$ 10,000	$ 0.10	$ 0.18
50,000	0.50	0.90
100,000	1.00	1.80
250,000	2.50	4.50
500,000	5.00	9.00
1,000,000	10.00	18.00

Plan Benefits

Employee Coverage

In the event of the death of a covered employee due to accidental bodily injury, the Plan will pay to the beneficiary the full amount of coverage (the principal sum). In order to be covered, the death must occur within one (1) year of the accident.

In the event a covered employee suffers a loss (other than death) as a result of accidental bodily injury, the Plan will pay to the employee the principal sum, or a portion of the principal sum. The loss must occur within one (1) year of the accident, and only the larger of the applicable sums will be paid if more than one loss results from the accident. The table below lists examples of accidental injuries covered under the Plan. A complete schedule of covered losses can be found in the underlying insurance contract. For a copy of the insurance contract, please contact the HR Service Center at 5-2363 (212-526-2363).

Examples of Accidental Injuries Covered Under the Plan:

Covered Loss	% of Principal Sum Payable to Employee
One hand or foot	50%
Thumb and index finger of same hand	25%
Total, permanent and irrecoverable loss of sight - both eyes	100%

Permanent Total Disability – Lump Sum Payment

Under the Plan, "permanent total disability" means that a covered employee is unable to engage in any occupation or employment for which he or she is suited by reason of education, training or experience for the remainder of his or her life.

The Plan will pay to a covered employee 1% of the Principal Sum (minus any sums paid for loss) for 100 months, after the covered employee has satisfied a 180 day elimination period, if the employee:

- Sustains permanent total disability because of a covered accidental bodily injury, within 180 days of the covered accident; and
- The permanent total disability continues for 180 days from the date of the accident.

Family Coverage

In the event of the death of a covered family member, the Plan will pay to the employee a portion of the principal sum as shown in the "Coverage" section. In the event a covered family member suffers a loss other than death, the Plan will pay to the employee a percentage of the family member portion of the principal sum as shown in the "Coverage" section.

Education Benefit

This benefit is payable to your qualified dependent child (or child's legal guardian) if you elect family coverage under the Plan and you die or sustain a Permanent and Total Disability in a covered accident. In

addition to all other benefits, the insurance company will pay 5% of your coverage amount over a four-year (consecutive) period (to a maximum of $7,500 per year) for each dependent child who:

On the date of the accident was enrolled as a full-time student in any institution of higher learning, or

Was in the 12th grade and within 365 days following the accident enrolls as a full-time student in an institution of higher learning. If no dependent child qualifies, $1,000 is paid.

Spouse Retraining Benefit

If you elect family coverage and you die in a covered accident, your spouse or domestic partner may receive an additional employment retraining benefit of 5% of the principal sum, up to a maximum of $7,500. Your spouse or domestic partner is eligible if, as a result of your death (within one year of the covered accident), he or she participates in a formal professional or trades training program for the purpose of obtaining an independent source of support and maintenance. The Plan will pay the actual cost of the retraining, up to 5% of the Principal Sum to a maximum of $7,500, provided that the spouse or domestic partner enrolls in an accredited school within thirty (36) months from the date of your death.

Increased Accident Benefit for Your Dependent Children

Severe accidental injuries to a child can result in ongoing and significant medical expenses, rehabilitation programs and the need for a specialized education environment. To help parents cope with the financial consequences, if a covered dependent child sustains a covered loss (other than loss of life), the Plan will pay an amount equal to two (2) times the sum payable for that loss, to a maximum of $100,000. However, this extra payment will only apply to the largest payment related to one accident. For example, a dependent child incurred 2 covered losses from one accident, one that would pay $50,000 and one that would pay $25,000 (based on the applicable principal sum and coverage levels). The plan would pay a benefit of $125,000, $75,000 for the total of the 2 covered losses and an additional $50,000 under this provision.

Day Care Benefit

If you die from a covered injury within 365 days of the date of your accident, the Plan will pay an additional day care benefit for each eligible dependent child.

A dependent child is eligible if, at the time of your accident, he or she is attending a day care program or has been enrolled in a day care program and will be attending within 365 days of the date of your death. The child must be under age thirteen (13) at the time of your death.

This Plan will pay the actual day care cost up to a maximum benefit of $3,000 annually over five (5) years, as long as the child is under age 13.

Additional Coverages

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses,* in the underlying Insurance Contract, and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

Armed Forces Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while he is on active duty in any Armed Forces.

National Guard and Armed Forces Reserve Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while the Covered Person is a member of the U.S. Military Reserve or National Guard.

While the Covered Person is a member of the U.S. Military Reserve or National Guard, coverage under this Policy will remain in force beyond the 31-day active duty training period and continue:

- during the Covered Person's initial training period;
- if the Covered Person is called to active duty for a domestic emergency.

Owned Aircraft Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by the Firm or any of its subsidiaries or affiliates. A record of eligible Aircraft will be maintained by the Firm and available for review by the insurer at any time upon their request. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction.

Pilot Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while the Covered Person is flying as a licensed pilot or member of the crew of an Aircraft that meets all of the following requirements:

1. has submitted a completed Pilot Data History form and has been accepted for Pilot coverage by the Life Insurance Company of North America;
2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by the Life Insurance Company of North America;
3. completes and maintains a combined minimum of 200 hours of military, private or professional logged flight hours
4. is flying as a pilot or member of the crew of an Aircraft for which he is qualified and on a list of eligible Aircraft maintained by the Firm, including a substitute Aircraft with no greater seating capacity while a listed Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction; and
5. is not giving or receiving flight instruction.

War Risk Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident

that occurs during war or acts of war that occur worldwide except for Afghanistan, Algeria, Chechnya, Iran, Iraq, Israel (including West Bank), Kuwait, Libya, Pakistan, Qatar, Saudi Arabia, Somalia, Turkey, and United Arab Emirates.

This benefit does not provide coverage when a Covered Loss occurs:

- in the United States and its territories and possessions; or
- in any nation of which the Covered Person is a citizen.

Benefit Reductions and Additional Benefits

Reduction at Age 70 and Over

While you are an active employee, upon attainment of certain ages, your coverage level will be reduced to a percentage of the Principal Sum. Please note that your premiums will still be based upon the Principal Sum, even though your coverage will be for a lower amount. Upon attainment of age 70, your coverage level will be reduced to 65% of your Principal Sum. Upon attainment of age 75, your coverage level will be reduced to 45% of your Principal Sum. Upon attainment of age 80, your coverage level will be reduced to 30% of your Principal Sum. Upon attainment of age 85, your coverage level will be reduced to 15% of your Principal Sum.

Exposure and Disappearance Benefit

If a Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident and an additional benefit of 10% of the principal sum, up to a maximum of $25,000, will be payable.

A Covered Loss resulting directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident will be covered under the Plan and a benefit will be paid out for a Covered Loss according to Schedule of Benefits for Covered Losses.

Seatbelt and Airbag Benefit

If a Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile, a seatbelt benefit of 10% of the Principal Sum, up to a maximum of $25,000, may be payable. An additional benefit of 5% of the Principal Sum, up to a maximum of $5,000, is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

If it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, a default benefit of $1,000 may be paid to the Covered Person's beneficiary.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.

Home Alteration and Vehicle Modification Benefit

A Home Alteration and Vehicle Modification Benefit of 10% of the Principal Sum, up to a maximum of $25,000, may be payable, subject to the following conditions and exclusions, when a Covered Person suffers a Covered Loss, other than a Loss of Life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. Prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. As a direct result of such Covered Loss, a Physician certifies that the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. The home alteration or vehicle modification is made:
    a. by a person qualified to make such alteration or modification; and
    b. in compliance with any applicable laws and regulations; and
    c. expenses for home alterations or vehicle modifications do not exceed those for similar alterations or modifications in the locality where they were made; and
    d. the Covered Person requires home alteration or vehicle modification within one year of the date of the Covered Accident.

Exclusions

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section of the underlying insurance contract:

- intentionally self-inflicted Injury, suicide or any attempt thereat;
- commission or attempt to commit a felony;
- commission of or active participation in a riot or insurrection;
- bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
- declared or undeclared war or act of war;
- flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface, except as:
    - a fare-paying passenger on a regularly scheduled commercial or charter airline;
    - a passenger in a non-scheduled, private aircraft used for pleasure purposes with no commercial intent during the flight; or
    - a passenger in a military aircraft flown by the air mobility command or its foreign equivalent;
- sickness, disease bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- travel in any aircraft owned, leased or controlled by the Firm, or any of its subsidiaries or affiliates. An aircraft will be deemed to be controlled by the Firm if the aircraft may be used as the Firm wishes for more than 10 straight days, or more than 15 days in any year;
- a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while

engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.

Benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is retained or employed by the Policyholder or is a parent, sibling, spouse or child of the Covered Person.

How to File a Claim

To report the accidental death or injury of a covered employee or family member, contact the HR Service Center at 5-2363 (212-526-2363). A Benefits Representative will contact the employee or the employee's beneficiary(ies), as applicable, directly in writing, requesting a copy of the death certificate, required tax information and copies of any and all accident/police reports as well as copies of any newspaper articles reporting the accident.

Any payment made under family coverage due to the death or injury of a covered dependent will be paid to the employee.

Death benefit information is confidential. No coverage or beneficiary information can be released without the beneficiary's consent. In the case of multiple beneficiaries, the HR Service Center will contact each beneficiary separately.

Converting to an Individual Policy

If you wish to convert all or a portion of your Personal Accident Insurance coverage to an individual policy with the Life Insurance Company of North America, contact the HR Service Center at 5-2363 (212-526-2363) and request a conversion application. You may request the application prior to your termination date.

Conversion coverage may not in any event exceed $250,000.

The HR Service Center will complete the employer portion of the application and forward it to your home. Premium information will be indicated on the application. These premiums are significantly higher than premium payroll deductions for active employees. After you have completed the application, forward it with your premium payment to the address listed on the back of the application.

The Life Insurance Company of North America must receive your application and premium payment within 31 days of your date of termination, or they will not issue an individual policy.

Business Travel Accident

The Business Travel Accident Plan (the "Plan") is underwritten by the Life Insurance Company of North America (Policy number ABL-980033). The Plan provides Firm-paid accidental death and dismemberment insurance for employees who are required to travel on behalf of the Firm. Business travel does not include your normal commute to and from your office.

Eligibility

All active regularly scheduled full-time employees of the Firm working 20 hours or more per week, regardless of home country location, and their guests are automatically covered under the Plan while traveling on behalf of the Firm. In addition, your spouse or domestic partner and dependent children (collectively "family members") may also be covered.

Plan Benefits

The amount of coverage provided is based on the covered individual's category, and the type of "loss" (including death) as described in the tables below.

Accidental Death Benefits

Employee Category	Death Benefits
All active full-time employees	5x Base pay, up to a maximum of $500,000
All Guests (except family members and as listed below)	$100,000

Accidental Injury Benefits

For accidental losses other than death, the Plan pays a percentage of the death benefit, if the loss occurs within 365 days of the covered accident. A complete schedule of covered losses can be found in the underlying insurance contract and is available upon request.

Covered Loss	% of Death Benefits Payable
Entire hand or foot	50%
Both hands or both feet	100%
Entire and irrecoverable loss of either speech or hearing	50%
Entire and irrecoverable loss of both speech and hearing	100%
Thumb and index finger of same hand	25%

Limitations

If a covered individual suffers more than one loss as a result of the same accident, the Plan will pay the greatest covered amount, but in no event more than the death benefit amount for that covered individual.

If one or more employees suffer a covered loss as a result of the same accident, the maximum the Plan will pay in the aggregate to all beneficiaries is $30,000,000 on a prorated basis.

If one or more employees suffer a covered loss as a result of a single bomb scare, search or explosion that occurs on the Firm's premises, the maximum the Plan will pay in the aggregate to all beneficiaries is $5,000,000 on a prorated basis.

Benefit Reductions and Additional Benefits

Reduction at Age 70 and Over

While you are an active employee, your coverage level will be reduced to a percentage of the Principal Sum. Upon attainment of age 70, your coverage level will be reduced to 65% of your Principal Sum. Upon attainment of age 75, your coverage level will be reduced to 45% of your Principal Sum. Upon attainment of age 80, your coverage level will be reduced to 30% of your Principal Sum. Upon attainment of age 85, your coverage level will be reduced to 15% of your Principal Sum.

Relocation Benefit

The spouse, domestic partner or dependent child of a covered employee may be covered by the Plan for any Covered Loss that occurs while relocating at the request of the Firm. Benefits payable for any loss or combination of losses are limited to 50% of the employee's principal sum, to a maximum of $100,000 for a spouse or domestic partner and $10,000 for a dependent child. To be eligible, a dependent child must be under age 19 and primarily dependent on the covered employee for support. Coverage may be extended to age 25 if the child is a full-time student attending an accredited college or university.

Common Carrier Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results, directly and independently of all other causes, from a Covered Accident that occurs while riding as a fare-paying passenger in, or being struck by, a Common Carrier. Riding includes getting into and out of the Common Carrier.

For purposes of this benefit, Common Carrier means:

- a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
- a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

Exposure and Disappearance Benefit

If a Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident and a benefit of 10% of the principal sum, up to a maximum of $25,000, will be payable.

A Covered Loss resulting directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident will be covered under the Plan and a benefit will be paid out for a Covered Loss according to Schedule of Benefits for Covered Losses.

Hijacking and Air Piracy Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting, directly and independently of all other causes, from a Covered Accident that occurs during the hijacking, air piracy, or unlawful seizure or attempted seizure of an Aircraft.

Owned Aircraft Coverage

A benefit will be payable, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss that results, directly and independently of all other causes, from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by the Firm or any of its subsidiaries or affiliates.

A record of eligible Aircraft must be maintained by the Firm and provided to the insurer upon request.

An Aircraft substituted for an eligible Aircraft will also be eligible if it is as similar to the original Aircraft in design and seating capacity as is available, and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction.

An Aircraft controlled by the Firm is one available for its use for 10 or more consecutive days or for 15 days during any calendar year.

Felonious Assault and Violent Crime Benefit

An additional benefit of up to 25% of the Principal Sum, up to a maximum of $100,000, will be payable, subject to all applicable conditions and exclusions, when a Covered Person suffers a Covered Loss resulting, directly and independently of all other causes, from a Covered Accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder.

To qualify for benefit payment, the Covered Accident must occur during any of the following:

- actual or attempted robbery or holdup;
- actual or attempted kidnapping; or
- any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

In addition, a Hospital Stay Benefit of $100 per day may be payable, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

- the Covered Person is covered for Hospital Stay benefits under this Policy;
- the Hospital Stay begins within 30 days of the felonious assault/violent crime;
- the Hospital Stay is at the direction and under the care of a Physician;
- the Covered Person provides proof satisfactory to the insurer that the Hospital Stay was necessitated to treat Covered Injuries sustained in a Covered Accident caused solely by a violent crime or felonious assault;

- the Hospital Stay begins while the Covered Person's insurance is in effect.

The benefit will be paid for each day of a continuous Hospital Stay, but the Maximum Benefit Period is 365 days per hospital stay per covered accident.

Seatbelt and Airbag Benefit

If a Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile, a seatbelt benefit of 10% of the Principal Sum, up to a maximum of $50,000, may be payable. An additional benefit of 5% of the Principal Sum, up to a maximum of $5,000, is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

If it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, a default benefit may be paid to the Covered Person's beneficiary.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.

Covered Events

The Plan covers losses incurred while on assignment by or at the direction of the Firm for furthering the business interests of the Firm. Side trips of a personal nature are covered provided that the side trip is incidental to the business trip, would not have occurred if not for the business trip, and does not last longer than 72 hours.

In addition, the Plan covers losses sustained as the result of a bomb scare, bomb search or bomb explosion on the Firm's premises.

Travel required during a covered employee's relocation is considered business travel. Regular commutation travel from a covered employee's home is not considered business travel.

Losses Not Covered

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Conditions of Coverages and Description of Indemnity Benefits sections of the underlying insurance contract.

- Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
- Commission or attempt to commit a felony or an assault;
- Commission of or active participation in a riot or insurrection;
- Declared or undeclared war or act of war;
- Flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    - except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
    - being flown by the Covered Person or in which the Covered Person is a member of the crew;
    - being used for:

        - crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; and
        - any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    - designed for flight above or beyond the earth's atmosphere;
    - an ultra-light or glider;
    - being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
    - being used for the purpose of parachuting or skydiving;
- Travel in or on any on-road and off-road motorized vehicle except a golf cart, that does not require licensing as a motor vehicle;
- Participation in any motorized race or contest of speed;
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- Travel in any Aircraft owned, leased or controlled by the Subscriber, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Subscriber if the Aircraft may be used as the Subscriber wishes for more than 10 straight days, or more than 15 days in any year;
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
- A Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
- An Accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Covered Person holds a valid learners permit and (b) the Covered Person is receiving instruction from a Driver's Education Instructor.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by the Subscriber;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
4. the Covered Person.

Benefits will not be paid for the Covered Person's Covered Loss if:

1. he was driving a Private Passenger Automobile at the time of the Covered Accident that resulted in the Covered Loss; and

2. he was intoxicated, as that term is defined by the laws of the state in which the Covered Accident occurred.

Beneficiary

In the case of the accidental death of a covered employee, the beneficiary is the beneficiary designated by that employee for Group Life Insurance coverage (see the "Naming a Beneficiary" section). You may designate a different beneficiary through the e-Benefits Web page within the Benefits section of LehmanLive (keyword: eBenefits). In the case of the accidental death of a covered dependent, the beneficiary is the employee.

How to File a Claim

To report the death or accidental injury of a covered employee, contact the HR Service Center at 5-2363 (212-526-2363). In the event of the death of a covered employee, the Benefits Representative will contact the beneficiary(ies) directly in writing, requesting a copy of the death certificate, required tax information and copies of any and all accident/police reports as well as copies of any newspaper articles reporting the accident.

Death benefit information is confidential. No coverage or beneficiary information can be released without the beneficiary's consent. In the case of multiple beneficiaries, the HR Service Center will contact each beneficiary separately.

Short Term Disability

The Short Term Disability (STD) Insurance Plan (the "STD Plan"), which is a fully insured plan, is a combination of state statutory programs and an insured program through MetLife. The Plan is designed to replace a portion of your income if you become totally disabled and cannot work. The "Definition of Totally Disabled" section under "Plan Benefits".

Eligibility and Enrollment

STD coverage is available on the first day of employment for all U.S. benefits-eligible employees (see the "Who Is Eligible for These Benefits" section). Hourly employees whose status changes to U.S. benefits-eligible are eligible for STD coverage on the day their status change takes effect.

Plan Benefits

STD Benefits

The STD plan provides a benefit of up to $500 a week or the state mandated maximum benefit as defined in the Benefit Programs section below. The benefits for employees working in California, Rhode Island, and Puerto Rico are paid directly by those states. The benefits for all other employees are paid by MetLife. All benefits under the STD plan must be coordinated with any benefit you may receive under the Firm's salary continuation program.

STD benefit payments begin after you have been totally disabled and unable to work for more than 7 consecutive days. Benefits are payable through your 26th week of disability, at which time you would become eligible for Long Term Disability ("LTD") benefits. Please see the LTD section of this document for a detailed description of the LTD program.

This benefit is provided by the Firm at no cost to you (except for certain required employee contributions in the statutory states). Enrollment in the STD Plan is automatic. STD benefits represent taxable income to you when paid.

Benefit Programs

Benefits paid directly by the individual states/territory

California – information on the California State Disability Insurance (SDI) program can be found at http://www.edd.ca.gov/direp/diind.htm

Puerto Rico - information on the Puerto Rico Temporary Disability Insurance (TDI) program can be found at http://www.gobierno.pr/gprportal/inicio

Rhode Island - information on the Rhode Island Temporary Disability Insurance (TDI) program can be found at http://www.dlt.state.ri.us/tdi/

Benefits paid through MetLife

The following lists the benefits available under the various STD programs that are paid through MetLife. Please contact the HR Service Center at HRServices@lehman.com or 212-526-2363 for more information regarding these STD programs.

- Hawaii - 58% of Insurance Earnings, maximum benefit is set by the state (2008 amount will be announced in December 2007)
- New Jersey – 66.67% of Insurance Earnings, maximum benefit is set by the state ($524 for 2008)
- New York – 60% of Insurance Earnings, maximum benefit of $500/week
- All other locations - 60% of Insurance Earnings, maximum benefit of $500/week

Definition of "Totally Disabled"

Under the STD Plan, "Totally Disabled" is defined as the inability to perform all the essential duties of your occupation. The MetLife, or the administrator of the statutory program for employees located in California, Puerto Rico or Rhode Island, makes all determinations regarding whether you qualify for full or partial disability benefits under the STD Plan.

MetLife will not make a determination regarding your disability without your signed medical disclosure authorization form and necessary documentation from your physician. You must contact MetLife as soon as possible to ensure there are no delays in obtaining any authorized benefits.

Long Term Disability

The Long Term Disability (LTD) Insurance Plan (the "LTD Plan"), which is a fully insured plan, is insured by MetLife. The Plan is designed to replace a portion of your income if you become totally disabled and cannot work. The "Definition of Totally Disabled" section under "Plan Benefits". LTD benefit payments begin after you have been totally disabled and unable to work for more than 180 consecutive days.

Eligibility and Enrollment

Both Basic LTD and Supplemental LTD coverages are available on the first day of employment for all U.S. benefits-eligible employees (see the "Who Is Eligible for These Benefits" section). Hourly employees whose status changes to U.S. benefits-eligible are eligible for LTD coverage on the day their status change takes effect.

Basic LTD

The Basic LTD plan provides coverage of 60% of your Insurance Earnings, up to a maximum of $50,000 of Insurance Earnings. This benefit is provided by the Firm at no cost to you. Enrollment in the Basic LTD plan is automatic. Basic LTD benefits represent taxable income to you when paid.

Supplemental LTD

The Supplemental LTD plan provides coverage of 60% of your Insurance Earnings over $50,000, up to a maximum of $300,000 of Insurance Earnings.

Supplemental LTD coverage is not automatic. Eligible employees must enroll within 31 days of their date of hire, or within 31 days of becoming an eligible employee due to a change in status. If your Insurance Earnings on your date of hire (or status change) are $50,000 or less, you will not pay a premium for Supplemental LTD coverage until your Insurance Earnings exceed $50,000. Supplemental LTD benefits are not taxable to you when paid.

Late Enrollment/Changing Your Enrollment

Employees who do not enroll in Supplemental LTD coverage within 31 days of hire (or change in employment status) will be required to furnish proof of good health before being accepted for coverage at a later date.

You may be eligible to enroll in Supplemental LTD without providing proof of good health if you undergo one of the family status changes listed below. If you have a family status change, you have 31 days from the qualifying event to enroll in Supplemental LTD. Send an email to the HR Service Center at hrservices@lehman.com with your name, social security number, event type and date of the event. An event will be created and you will need to go through the e-Benefits Web page within the Benefits section of LehmanLive (keyword: eBenefits) to make the changes.

The following constitute a Qualified Family Status Changes:

- Marriage or domestic partnership;
- Divorce, legal separation or termination of domestic partnership;

- Birth or adoption of a child; legal guardianship of a child;
- Spouse or domestic partner becomes unemployed, loses coverage or takes unpaid leave of absence;
- Employee takes an unpaid leave of absence;
- Dependent child returns to school full-time;
- Death of a dependent;
- Spouse or domestic partner becomes employed.

Use of Insurance Earnings to Determine LTD Benefits

Coverage amounts for Basic and Supplemental LTD are based on your Insurance Earnings, and change automatically with the annual recalculation of Insurance Earnings on April 1st. If your Insurance Earnings increase, your LTD coverage will also increase, unless you have reached the maximum ($50,000 for Basic, $300,000 for Supplemental). If your Insurance Earnings decrease, your LTD coverage will also decrease.

If your coverage amounts increase because your Insurance Earnings have increased, you will not be required to submit proof of good health to the insurance company. Your increased coverage will be adjusted automatically after the April 1st recalculation.

If you become disabled, your benefit amount is based on the Insurance Earnings in effect on the last day you worked. See the "Monthly Benefit Calculation" section in "Plan Benefits" for details.

Cost of Coverage

Your annual cost for Supplemental LTD coverage is $0.33 per $100 of Insurance Earnings in excess of $50,000 to a maximum of $300,000 of Insurance Earnings.

For example, if your Insurance Earnings are $150,000, the first $50,000 of your earnings is insured under the Basic LTD Plan at no cost to you. The additional $100,000 of your earnings is insured under the Supplemental LTD Plan at a cost of $330 per year ($27.50 per month). Monthly premiums are calculated by dividing the annual cost by 12. Examples of monthly premiums can be found on the chart below.

Examples of LTD Premiums and Benefits

Insurance Earnings	Annual Disability Income	Monthly Disability Benefit	Monthly Premium
$25,000	$15,000	$1,250	Firm-paid
$50,000	$30,000	$2,500	Firm-paid
$100,000	$60,000	$5,000	$13.75
$150,000	$90,000	$7,500	$27.50
$200,000	$120,000	$10,000	$41.25
$250,000	$150,000	$12,500	$55.00
$300,000	$180,000	$15,000	$68.75
Over $300,000	$180,000	$15,000	$68.75

Employee contributions for Supplemental LTD coverage are made on an after-tax basis. Deductions for Supplemental LTD coverage will appear on your pay stub under "After-Tax Deductions."

Plan Benefits

The LTD Plan insures a percentage of your Insurance Earnings. If you elect Supplemental LTD coverage and your Insurance Earnings are $150,000, for example, your premiums and coverage are based on those earnings, not the maximum earnings of the Plan.

Definition of "Totally Disabled"

Under the LTD Plan, "Totally Disabled" is defined as the inability to perform all the essential duties of your occupation.

If you are enrolled in the Basic and Supplemental LTD plans, the definition of Totally Disabled listed above will be in effect until the later of age 65 or your Disability End Date.

If you are only enrolled in the Basic LTD plan, after monthly benefits have been payable for 24 months, "total disability" is defined as the inability to perform all the essential duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

Determinations

The insurance company makes all determinations of whether you qualify for full or partial disability benefits under the LTD Plan.

Partial Disability

Partial disability means that, because of illness or injury, you are unable to perform all essential duties of your own occupation on a full-time basis, but:

You are able to perform at least ***one*** of the material duties of your own or another occupation on a part-time or full-time basis; and

You are now earning ***at least 20%*** less than your indexed prior earnings, due solely to that disability.

Your partial disability monthly benefit is calculated based on a percentage of earnings and of total disability benefits. **For example**, if your earnings while partially disabled equal 40% of your earnings before you were disabled, your partial disability monthly benefit would equal 60% of your total disability monthly benefit.

Partial disability must start within 31 days after the end of a period of total disability for which monthly benefits are payable and must result from the same injury or sickness that caused you to be totally disabled.

Successive Periods of Disability

Separate periods of total disability resulting from the same or related causes will be considered one period of total disability unless separated by your return to active service for at least six (6) consecutive months.

Separate periods of total disability resulting from unrelated causes will be considered one period of total disability unless separated by your return to active service for at least one (1) full day.

Monthly Benefit Calculation

The LTD Plan is designed to provide you with income while you are unable to work due to a covered disability. The term "monthly benefit" refers to the amount payable to you on a monthly basis under the terms of the LTD Plan. Your monthly benefit is determined based on your Insurance Earnings in effect your last day worked and is calculated by taking 60% of your Insurance Earnings (or the coverage maximum, whichever is less) and dividing it by 12.

For example, if you become disabled and your last day of work is November 11, 2007, you will become eligible for monthly benefits beginning May 9, 2007. However, your benefit amount is based on the Insurance Earnings in effect on the last day you worked. In this example, the Insurance Earnings in effect would be those calculated on April 1, 2007 or your date of hire, if later, but not those recalculated on April 1, 2008.

Length of Disability

When Monthly Benefits Begin

If you become totally disabled while covered under the LTD Plan, you will be eligible to receive monthly benefits beginning on the 181st day following your last day worked.

When Monthly Benefits End

Except for disabilities contributed to or caused by mental illness or substance abuse (see the "Mental Illness and/or Substance Abuse" section under "Limitations and Exclusions"), monthly benefits will end on the earlier of:

The date you are no longer disabled (as determined by the insurer), or

Whichever of the end dates on the table is applicable to you.

Disability End Dates

Age When Total Disability Begins	Date Monthly Benefits End
Age 62 or Under	Later of: (i) your 65th birthday; or (ii) date the 42nd monthly benefit is payable
Age 63	Date the 36th monthly benefit is payable
Age 64	Date the 30th monthly benefit is payable
Age 65	Date the 24th monthly benefit is payable
Age 66	Date the 21st monthly benefit is payable
Age 67	Date the 18th monthly benefit is payable
Age 68	Date the 15th monthly benefit is payable
Age 69 or Over	Date of the 12th monthly benefit is payable

Benefit Offset

The actual amount of your monthly LTD benefits will take into consideration other disability income you receive. The LTD benefit will be reduced by the following:

- Any amounts you or your dependents receive on account of your disability under:
  - The Firm's salary continuation policy;
  - Any state disability or retirement benefits which you receive, or are assumed to receive (see "Assumed Receipt of Benefits" below) on your own behalf;
  - Any group or franchise insurance or similar plan for persons in a group; the Canada and Quebec Pension Plans;
  - Any local, provincial or federal government disability or retirement plan or law;
  - The Jones Act, or any workers' compensation, occupational disease or similar law including all permanent as well as temporary disability benefits; and
  - Any work loss provision in the mandatory part of any "No-Fault" auto insurance policy;
  - Unemployment Insurance Law or Program;
  - Work Earnings and Rehabilitation Incentive.
- Any disability or old age benefits payable under the federal Social Security Act which you receive or are assumed to receive (see "Assumed Receipt of Benefits" below) on your own behalf, on behalf of your dependents, or which your dependents receive on account of your receipt or assumed receipt (see "Assumed Receipt of Benefits" below) of such benefits.
- Any retirement benefits which you receive under (a) the Lehman Brothers Holdings Inc. Retirement Plan; (b) the Railroad Retirement Act or the Railroad Unemployment Act, to the extent these benefits are funded by the Employer.

Payments under an individually owned disability policy do not reduce your benefit under the Firm-sponsored LTD Plan.

Assumed Receipt of Benefits

If you are covered under the U.S. Social Security Act for any disability or old age benefit, state disability (if applicable), workers' compensation or similar laws, you must file for these benefits and you will be assumed to be receiving such benefits for yourself (and for your dependents, if applicable). These "assumed benefits" will be the amount the insurance company estimates you (and your dependents, if applicable) are eligible to receive. This assumption will not be made if you give proof that:

1. You have applied for these benefits; and
2. Payments were denied.

However, if payments for disability are denied solely because your disability is not expected to last at least 12 consecutive months, you will be assumed to be receiving such benefits after your disability has continued for 12 consecutive months. This assumption will not be made if you give proof that:

1. You have re-applied for these benefits; and
2. Payments were again denied.

MetLife will not assume receipt of, nor reduce your monthly benefits by, any elective, actuarially reduced early retirement benefits under such laws unless and until you actually receive such benefits.

Maximum Monthly Benefits

The maximum monthly benefit is $2,500 under the Basic LTD Plan and $12,500 under the Supplemental LTD Plan, for a total (including family Social Security disability) of $15,000. This benefit is reduced by any other disability or retirement or pension benefit. See the "Benefit Offset" section above.

Family Survivor Benefits

If you die while you are receiving a monthly LTD benefit and you had collected LTD monthly benefits for a least six (6) months at the time of your death, your eligible survivor may be eligible to receive a survivor benefit equal to three (3) times your monthly LTD benefit. Your eligible survivor is your lawful spouse; otherwise, your unmarried child(ren) under age 25 who are living with you at the time of your death, in equal shares. Family survivor benefits will not be paid if there is no lawful spouse or any unmarried child(ren).

Lehman Brothers Benefits

If you were enrolled in the Medical, Dental or Vision Plan while you were active, you are entitled to continue your coverage while you are on LTD. You will be required to pay the employee cost of the premiums (equal to the active employee premium) and the Firm will pay the employer cost. MetLife can deduct those payments automatically from your LTD disability benefit check. Your eligible dependents can remain enrolled as long as they meet the eligibility requirements. You cannot add additional dependents while you are on LTD.

Your Basic Group Term Life Insurance remains in effect. You may elect to continue your Supplemental Group Term Life insurance without continuing to pay premiums if you complete a waiver of premium form and submit to MetLife. MassMutual will contact you directly regarding premium payments to continue GVUL coverage.

You can continue to keep your Flexible Spending Account active for the remainder of the first calendar year in which you become disabled through COBRA. Contributions to your account will be made on an after-tax basis.

At such time that you are no longer disabled or eligible for LTD benefits (e.g. reach age 65), your Lehman Brothers benefits will cease effective immediately.

Limitations and Exclusions

Pre-existing Condition Exclusion

If you become disabled during your first 12 months of coverage under the LTD Plan, no benefits will be paid if your disability results directly or indirectly from a "pre-existing condition."

A pre-existing condition is defined as an injury or sickness in which, during the three (3) months prior to becoming covered under the Plan, you:

- Incurred expenses;
- Received medical treatment;
- Took prescribed drugs or medicines; or
- Consulted a physician.

Mental Illness and/or Substance Abuse

The Plan will pay monthly benefits for no more than 24 months during your lifetime for any total disability or partial disability caused or contributed to by one or more of the following:

- Alcoholism
- Psychotic, depressive, anxiety or eating disorders
- Delusional (paranoid) disorders
- Drug addiction or abuse
- Somatoform disorders (psychosomatic illness)
- Mental illness

This limitation does not apply for any period of time during which an employee is confined for more than 14 consecutive days in a hospital licensed to provide care and treatment for the condition causing total disability.

You will be considered confined in a hospital only if you are confined continuously for at least 14 days in a hospital licensed to provide care and treatment for the condition causing the total disability.

Other Exclusions

The LTD Plan does not cover any disability caused by or resulting from the following:

- War, declared or undeclared, or any act of war;
- Intentionally self-inflicted injuries;
- Committing a felony; or
- Active participation in a riot.

No monthly benefit will be paid for any period of total disability when you are not under the care of a licensed physician.

No benefits will be paid for any period of partial disability during which your loss of earnings is not solely due to disability.

How to File a Claim

If you become unable to work due to illness or injury, contact the Lehman Brothers HR Service Center at 5-2363 (212-526-2363) to begin processing your claim for disability benefits. If your disability lasts longer than three (3) months, you will be contacted by both the HR Service Center and the MetLife Insurance Company, the LTD Plan's insurance company, to begin the LTD claims process.

Under this Plan, you are required to file for Social Security disability benefits. Also, if you are age 65 or older, you are required to begin collecting your Lehman Brothers Holdings Inc. Retirement Plan benefit. See the "Assumed Receipt of Benefits" section under "Plan Benefits."

You will not qualify for LTD monthly benefits until after the 180-day waiting period has been satisfied. However, you will be asked to supply certain information in advance of that date in order to ensure that your monthly benefits begin as soon as your claim has been approved.

MetLife will supply you with the necessary claim forms and will require proof of disability from your doctor. This proof must describe the occurrence, character and extent of your disability. In addition, the

insurance company has the right, at its expense, to examine you as often as they may reasonably require in order to ascertain the extent of your disability.

Converting Your LTD Coverage

You will be entitled to convert your LTD Plan coverage to a conversion policy if:

- Your coverage under the Plan ends due to resignation or involuntary termination of employment; and
- You have been insured under the LTD Plan for at least 12 consecutive months.

You are not entitled to convert your coverage to an individual policy if:

- Your employment status changes to hourly, seasonal or temporary; or
- You have attained age 70; or
- You are retired.

ERISA Rights and Other Important Information

Plan Administration

There may be times when you need special information about the Lehman Brothers Holdings Inc. Group Benefits Plan (the "Plan"). This section provides technical information about the Plan. It is also designed to make information on the Plan easier to find.

Sponsoring Employer and Funding

The Plan is sponsored by:	The Sponsor's Employer Identification Number is:
Lehman Brothers Holdings Inc. 745 7th Avenue New York, NY 10019	13-3216325

The self-funded benefits under the Plan (the Medical Plan, Dental Plan and the Flexible Spending Accounts) are funded by employee and Firm contributions. Benefits under these self-funded benefits are not guaranteed or insured. Firm contributions are made directly from general assets of the Firm.

The method for funding the insured benefits (the Vision Care, Group Term Life, Personal Accident Insurance, Business Travel Accident and Long Term Disability Plans) is for the Firm to pay premiums for the insurance benefits from its general assets, after any required contribution for insurance benefits are obtained from the employees by payroll deduction. To the extent that the premiums paid, other than premiums paid for coverage provided on a pooled basis, exceed the final premium costs for any policy year, the excess will be returned to and retained by the Firm and will not become an asset of the Plan. However, for the insured parts of the Plan which require employee contributions, to the extent such premium excess exceeds the Firm's contributions for the insurance premiums, including the costs expended to administer the Plan, that amount will be applied by the Firm for the sole benefit of the employees participating in the Plan.

Plan Type and Plan Year

The Plan is a welfare benefit plan and a section 125 fringe benefit plan under the Internal Revenue Service guidelines for employer-sponsored benefit plans.

The Plan year is January 1 through December 31.

Agent for Legal Service

The agent for service of legal process for the Plan is:

Chairperson of the Employee Benefit Plans Committee
Lehman Brothers HR Service Center
1301 Avenue of the Americas, 6th Floor
New York, NY 10019

However, service of legal process may also be made on the Plan Administrator described in the "Plan Administrator" section below.

Plan Administrator

The Medical and Dental Plans and the Flexible Spending Accounts are administered by the Employee Benefit Plans Committee of Lehman Brothers Holdings Inc. (the "Committee"). The Committee can be reached at:

Employee Benefit Plans Committee
c/o HR Service Center
Lehman Brothers Inc.
1301 Avenue of the Americas, 6th Floor
New York, NY 10019
212-526-2363

The Plan Administrator is responsible for the operation and general administration of the Plan. The Committee has appointed a "Claims Administrator" for the Medical, Dental and Flexible Spending Account Plans to act on the Committee's behalf in administering and processing claims submitted under those plans. See the table below for the name and address of the Claims Administrators.

Claims Administrators

Benefit Plan	Claims Administrator
Aetna Choice POS II (Medical)	Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106
MetLife (Dental)	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282
Flexible Spending Account	WageWorks 4129 East Van Buren Suite 220A Phoenix, AZ 85008

The Vision Care, Group Term Life, Personal Accident Insurance, Business Travel Accident and Long Term Disability plans are each administered by the underwriting insurance company. See the table below for the names and addresses of the various plan administrators.

Benefit Plan	Plan Administrator
Vision Care	Davis Vision P.O. Box 2270 Schenectady, NY 12301
Group Term Life Insurance	MetLife P.O. Box 6115 Utica, NY 13504-6115
Personal Accident Insurance and Business Travel Accident	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
Long Term Disability	Met Life P.O. Box 14590 Lexington, KY 40511-4590

Plan Administrators

The Plan Administrator has the discretionary authority to make all decisions in connection with the administration of the welfare benefit plans including, but not limited to, decisions concerning the eligibility of any person to participate in the welfare benefit plans and any benefits to which a participant or beneficiary is entitled. The Plan Administrator is the final authority concerning the welfare benefit plans. The Plan Administrator may adopt rules and regulations for administering the welfare benefit plans, including the limits on salary deductions. The Plan Administrator may prescribe forms for use by participants and their beneficiaries in communicating with the Plan Administrator. The Plan Administrator may establish periods during which communications or elections may be received. The Plan Administrator is not required to accept or give effect to any communications or elections which are not made on the forms provided or filed during the required periods.

Pursuant to procedures established by the Plan Administrator, any participant whose claim for benefits under a welfare benefit plan has been denied has the right to appeal such denial to the Plan Administrator for its review. Decisions and determinations of the Plan Administrator are final, conclusive and binding upon all parties, including the Firm, its employees, the participants and their beneficiary or beneficiaries.

Claiming Your Benefits

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Group Health Urgent Care Claims

If a group health plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"Urgent Care" means services received for a sudden illness, injury or condition that is not an emergency condition but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person's health; this includes a condition that would subject a person to severe pain that could not be adequately managed without prompt treatment.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 24 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Group Health Pre-Service and Post-Service

If a group health Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other group health claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you are receiving an ongoing course of medical treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Disability/Other Claims

For disability claims, you will be notified of the Claims Administrator's determination no later than 45 days after receipt of your claim. For all other claims you will be notified no later than 90 days after receipt of the claim.

Appealing Your Claim

It is possible for an error to occur in your records or in processing your claim. For this reason, there is an appeals procedure which is available to you if your claim is denied.

You will have two levels of appeal for both administrative and clinical appeals in accordance with the definitions below.

Administrative appeals are defined as appeals in response to denials based on contractual or benefit exclusion, limitation, or exhaustion not requiring clinical judgment. Administrative denials do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.

Clinical appeals are defined as appeals in response to denials based on clinical judgment for the determination and application the terms of the plan to the member's medical circumstances

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to the Claims Administrator. For group health portions of the Plan, you will be notified of the decision not later than 15 days (for pre-service claims, or 30 days for post-service claims, after the appeal is received. For disability claims, you will be notified within 45 days after the appeal is received. For all other claims, you will be notified within 60 days after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care under the Medical Plan, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card.

You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with an appeal decision that involves urgent care, you may file a second level appeal to the Claims Administrator on an expedited basis. The second level appeal will be processed in the same manner as the first level appeal and you will be notified of the decision by the Claims Administrator no later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision other than urgent care, you may file a second level appeal to the Company within 60 days of receipt of the level one appeal decision. Send your appeal request to the Claims Administrator and they will forward your appeal request and any additional information you have provided, along with the level one appeal file, to the Company. The Company will notify you of the decision no later than 15 days for pre-service claims 30 days for post-service claims, 45 days for disability claims, or 60 days for all other claims, after the appeal is received.

If your claim is denied in whole or in part, you will be notified in writing of:

1. The reason(s) for the denial, with reference to the specific Plan provisions on which the denial is based;
2. A description of any additional material needed to be filed with your claim, and an explanation as to why such information is needed; incomplete claims will be treated as part of the request for information and extension process and not as a denial unless you do not respond to the request for information within the required time period;
3. Instructions and deadlines for how to make an appeal, including a statement of your right to file a lawsuit under ERISA if your appeal is denied; and
4. In the case of a health care claim involving urgent care, a description of the expedited review process for these types of claims

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you establish any:

- litigation;
- arbitration; or
- administrative proceeding:

- regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or
- regarding any matter within the scope of the Appeals Procedure.

Health Claims – Voluntary Appeals

You may file a voluntary appeal for external review of any final standard appeal determination that qualifies.

You must complete all of the levels of standard appeal described above before you can appeal for external review. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice under the standard appeal processes.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Health Claim Appeals for External Review

Aetna's external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

1. the standard levels of appeal have been exhausted,
2. the appeal is made by the member or the member's authorized representative,
3. the coverage denial is based on Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
4. the cost of the service or supply at issue for which the member is financially responsible exceeds $500.

If upon the final standard level of appeal the Company upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. The decision of the independent external expert reviewer is binding on Aetna, the Company and the Health Plan. Members will not be charged a professional fee for the review.

Appeal to Plan Administrator

If a denial of benefits is upheld following the Level two process of the Appeal Procedure, you have the right to appeal to the Plan Administrator. With the exception of urgent care claims, you will have 180 days following receipt of an adverse benefit decision to appeal the decision. You must submit a complete, written application to the Plan Administrator requesting that your claim be reconsidered. You must state the reason(s) you think there is an error. Also, whenever possible, send copies of any documents or records that support your appeal. Whether or not you can provide such additional

information, your claim will be thoroughly reconsidered after your request is received. You are entitled to review all the Plan documents when you prepare your appeal and to have a qualified person represent you, at your own expense, during the appeals process.

You will be notified of the decision no later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

All decisions of the Plan Administrator are final, conclusive and binding. If, however, you believe that the Plan Administrator did not follow the terms of the Plan or has violated law, you may bring a legal action under ERISA. See the "ERISA Rights" section.

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted the Plan's mandatory levels of administrative process as described in this Summary Plan Description. If your appeal is denied you have the right to file a lawsuit under ERISA, provided you do so before the earliest of:

- Six months following the date your appeal has been denied
- Three years following the services related to the amount you are appealing were performed, or
- The end of the otherwise applicable statutory limitation period.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such

coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact:

- The nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") directed the Department of Health and Human Services to issue regulations protecting the privacy and confidentiality of individual health information.

In connection with the HIPAA rules, the Plan has been amended to permit the Firm to receive certain participant health information. The Firm only will request this information if it needs it to help administer the Plan, such as to help resolve disputed claims. The Firm will protect the confidentiality of any health information that it does receive.

As part of the HIPAA rules, a health plan must notify its participants and beneficiaries about the policies and practices the plan adopted to protect the confidentiality of the participants' health information. For this purpose, the Plan has prepared a Privacy Statement, which has been separately distributed to you and also is available on the Firm's website.

The Plan's Privacy Statement describes the Plan's health information privacy policy regarding the Aetna Open Choice POS II and its related prescription drug benefits, the MetLife Dental Plan and the Health Care Flexible Spending Account ("FSA"). The Privacy Statement is intended to inform you of:

- your rights regarding your personal health information,
- the way the Plan may use and disclose health information about you, and
- the obligations the Plan has regarding the use and disclosure of your health information.

If you are enrolled in the International Medical Plan, International Dental Plan or if you are enrolled in the Davis Vision Care Plan, you should receive a separate privacy notice from your benefits provider that outlines the privacy policies and practices of your specific benefits option.

The Plan's Privacy Statement also does not address the privacy policies or practices of your health care providers.

Other Important Information

Changing or Terminating the Plans

The Firm reserves the right to amend or terminate any or all of the Plans at any time without prior notice or consent. The Firm's decision to amend or terminate a Plan may be due to changes in federal or state laws governing retirement benefits, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), employee or Firm needs, or for any other reason. Plan participants will be given additional information in the event a Plan is amended or terminated.

Pension Benefit Guarantee Corporation

Benefits under the welfare benefit plans are not insured by the Pension Benefit Guaranty Corporation or any other governmental agency.

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re	:	**Chapter 11 Case No.**
	:	
LEHMAN BROTHERS HOLDINGS INC., *et al.*,	:	**08-13555 (JMP)**
	:	
Debtors.	:	**(Jointly Administered)**

ORDER GRANTING THREE HUNDRED FORTY-FIRST OMNIBUS OBJECTION TO CLAIMS (NO LIABILITY CLAIMS)

Upon the three hundred forty-first omnibus objection to claims, dated August 14, 2012 (the "Three Hundred Forty-First Omnibus Objection to Claims"),[2] of Lehman Brothers Holdings Inc. ("LBHI"), as Plan Administrator under the Modified Third Amended Joint Chapter 11 Plan of Lehman Brothers Holdings Inc. and its Affiliated Debtors, pursuant to section 502(b) of title 11 of the United States Code (the "Bankruptcy Code"), Rule 3007(d) of the Federal Rules of Bankruptcy Procedure, and this Court's order approving procedures for the filing of omnibus objections to proofs of claim [ECF No. 6664], seeking disallowance and expungement of the No Liability Claims on the basis that LBHI has no liability for such claims, all as more fully described in the Three Hundred Forty-First Omnibus Objection to Claims; and due and proper notice of the Three Hundred Forty-First Omnibus Objection to Claims having been provided, and it appearing that no other or further notice need be provided; and the Court having found and determined that the relief requested in the Three Hundred Forty-First Omnibus Objection to Claims is in the best interests of the Chapter 11 Estates, their creditors, and all parties in interest, and that the legal and factual bases set forth in the Three Hundred Forty-First Omnibus

[2] Capitalized terms used herein and not otherwise defined herein shall have the meanings ascribed to such terms in the Three Hundred Forty-First Omnibus Objection to Claims.

Objection to Claims establish just cause for the relief granted herein; and after due deliberation and sufficient cause appearing therefor, it is

ORDERED that the relief requested in the Three Hundred Forty-First Omnibus Objection to Claims is granted to the extent provided herein; and it is further

ORDERED that pursuant to section 502(b) of the Bankruptcy Code, the portions of the claims listed on Exhibit 1 that assert No Liability Claims are disallowed and expunged with prejudice; and it is further

ORDERED that this Order has no res judicata, estoppel, or other effect on the validity, allowance, or disallowance of, and all rights to object and defend on any basis are expressly reserved with respect to any claim listed on Exhibit A annexed to the Three Hundred Forty-First Omnibus Objection to Claims that is not listed on Exhibit 1 annexed hereto; and it is further

ORDERED that this Court shall retain jurisdiction to hear and determine all matters arising from or related to this Order.

Dated: _____, 2012
New York, New York

_____
UNITED STATES BANKRUPTCY JUDGE